

ACTION ON THE SOCIAL DETERMINANTS OF HEALTH: LEARNING FROM PREVIOUS EXPERIENCES

Social Determinants of Health Discussion Paper 1

DEBATES, POLICY & PRACTICE, CASE STUDIES

ACTION ON THE SOCIAL
DETERMINANTS OF
HEALTH:
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PREVIOUS EXPERIENCES

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The Discussion Paper Series on Social Determinants of Health provides a forum for sharing knowledge on how to tackle the social determinants of health to improve health equity. Papers explore themes related to questions of strategy, governance, tools, and capacity building. They aim to review country experiences with an eye to understanding practice, innovations, and encouraging frank debate on the connections between health and the broader policy environment. Papers are all peer-reviewed.

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This paper was prepared for the launch of the Commission on Social Determinants of Health (CSDH) by its secretariat based at WHO in Geneva. It was discussed by the Commissioners and then revised considering their input. It was written by Alec Irwin and Elena Scali.

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Executive summary

Today an unprecedented opportunity exists to improve health in some of the world's poorest and most vulnerable communities by tackling the root causes of disease and health inequalities. The most powerful of these causes are the social conditions in which people live and work, referred to as the social determinants of health (SDH). The Millennium Development Goals (MDGs) shape the current global development agenda. The MDGs recognize the interdependence of health and social conditions and present an opportunity to promote health policies that tackle the social roots of unfair and avoidable human suffering.

The Commission on Social Determinants of Health (CSDH) is poised for leadership in this process. To reach its objectives, however, the CSDH must learn from the history of previous attempts to spur action on SDH. This paper pursues three questions: (1) Why didn't previous efforts to promote health policies on social determinants succeed? (2) Why do we think the CSDH can do better? (3) What can the Commission learn from previous experiences – negative and positive – that can increase its chances for success?

Strongly affirmed in the 1948 WHO Constitution, the social dimensions of health were eclipsed during the subsequent public health era dominated by technology-based vertical programmes. The social determinants of health and the need for intersectoral action to address them re-emerged strongly in the Health for All movement under the leadership of Halfdan Mahler. Intersectoral action on SDH was central to the model of comprehensive primary health care proposed to drive the Health for All agenda following the 1978 Alma-Ata conference. During this period, some low-income countries made important strides in improving population health statistics through approaches involving action on key social determinants. Rapidly, however, a scaled-back version of primary health care, “selective primary health care”, gained influence. Selective primary health care focused on a small number of cost-effective interventions and downplayed the social dimension. The most important example of selective primary health care was the GOBI strategy (growth monitoring, oral rehydration, breastfeeding and immunization) promoted by UNICEF in its “child survival revolution”. The contrast in approaches between comprehensive and selective PHC raises strategic questions for the CSDH.

Like other aspects of comprehensive primary health care, action on determinants was weakened by the neoliberal economic and political consensus dominant in the 1980s and beyond, with its focus on privatization, deregulation, shrinking states and freeing markets. Under the prolonged ascendancy of variants of neoliberalism, state-led action to improve health by addressing underlying social inequities appeared unfeasible in many contexts. The 1990s saw an increasing influence of the World Bank in global health policy, with mixed messages from WHO. During this period, however, important scientific advances emerged in the understanding of SDH, and in the late 1990s several countries, particularly in Europe, began to design and implement innovative health policies to improve health and reduce health inequalities through action on SDH. These policies targeted different entry points. The more ambitious aimed to alter patterns of inequality in society through far-reaching redistributive mechanisms. Less radical, palliative programmes sought to protect disadvantaged populations against specific forms of exposure and vulnerability linked to their lower socioeconomic status.

The 2000s have seen a pendulum swing in global health politics. Health stands higher than ever on the international development agenda, and stakeholders increasingly acknowledge the inadequacy of health strategies that fail to address the social roots of illness and well-being. Momentum for action on the social dimensions of health is building. The Millennium Development Goals were adopted by 189 countries at the United Nations Millennium Summit in 2000. They set ambitious targets in poverty and hunger reduction; education; women's empowerment; child health; maternal health; control of epidemic diseases; environmental protection; and the development of a fair global trading system, to be reached by 2015. The MDGs have created a favourable climate for multisectoral action and underscored connections between health and social factors. An increasing number of countries are implementing SDH policies, but there is an urgent need to expand this momentum to developing countries where the effects of SDH are most damaging for human welfare. This is the context in which the CSDH will begin its work.

Based on the historical survey, four key issue areas are highlighted, in which the members of the CSDH must take strategic decisions early in their process.

- ① The first concerns the scope of change the Commission will seek to promote and appropriate policy entry points. Here the CSDH will face its own version of the choice between comprehensive and selective primary health care that confronted public health leaders in the 1980s. **The CSDH will need evaluation criteria for identifying appropriate policy entry points for different countries/jurisdictions.**
- ② Potential resistance to CSDH messages can be anticipated from several constituencies, which the Commission should seek to engage proactively. **The Commission will want to identify a set of potential “quick wins” for itself and for national political leaders taking up an SDH agenda.** Commissioners will want to develop a strategy for dialogue with the international financial institutions, in particular the World Bank.
- ③ The CSDH will also benefit from exceptional political opportunities. It will effectively position itself within the global and national processes connected to the MDGs. **Alliances with both the business community and civil society are possible, but competing interests will need to be managed.** The opportunity and limits of economic arguments for SDH policies remain to be clarified, and such arguments raise deeper ethical questions.
- ④ In addition to robust evidence, **the Commission needs a compelling, collectively owned “story line” about the social determinants of health,** in which the evidence can be embedded and communicated. What story does the CSDH want to tell about social conditions and human well-being?

With answer to these questions in place, the Commission will lead a global effort to protect vulnerable families and secure the health of future generations by tackling disease and suffering at their roots.

1 Introduction

Today health stands higher than ever on the international development agenda, and health inequalities between and within countries have emerged as a central concern for the global community^{1,2,3,4}. An unprecedented opportunity exists to improve health in some of the world's poorest and most vulnerable communities – if approaches are chosen that tackle the real causes of health problems. The most powerful of these causes are the social conditions in which people live and work, referred to as the social determinants of health (SDH). Social determinants reflect people's different positions in the social “ladder” of status, power and resources. Evidence shows that most of the global burden of disease and the bulk of health inequalities are caused by social determinants^{5,6}.

The Millennium Development Goals (MDGs) recognize this interdependence between health and social conditions. The MDG framework shows that without significant gains in poverty reduction, food security, education, women's empowerment and improved living conditions in slums, many countries will not attain health targets^{7,8}. And without progress in health, other MDG objectives will also remain beyond reach. Today, an international development agenda shaped by the MDGs provides a crucial opportunity to promote health policies that tackle the social roots of unfair and avoidable human suffering.

The Commission on Social Determinants of Health (CSDH) is poised for leadership in this process. To reach its objectives, however, the CSDH must learn from history. In the 1970s and 80s, the global Health for All strategy emphasized the need to address social determinants, yet

these recommendations were rarely translated into effective policies. Strong messages on SDH emerged again in the mid-1990s, but once more policy implementation made little headway in the developing countries where needs are greatest. Understanding the reasons for these frustrations is fundamental to planning an effective strategy for the CSDH.

As an input to the strategy process, this paper seeks to shed light on three related questions:

- 1 Why didn't previous efforts to promote health policies on social determinants succeed?
- 2 Why do we think the CSDH can do better?
- 3 What can the Commission learn from previous experiences – negative and positive – that can increase its chances for success?

The first part of this study reviews previous major efforts to address social determinants with attention to these efforts' political contexts. The second part identifies a series of key strategic issues based on the historical record and outlines factors that should enable the CSDH to catalyse effective action.

An issue of vocabulary requires preliminary clarification. One of the Commission's main messages is that policies and interventions well beyond the traditional health sector should be understood as part of a robust health policy. “Health policy” is not equal to “health care policy”. In the following pages, terms such as “SDH policies” and “SDH approaches” are used as a time-saving shorthand. These terms refer to *health policies that address the social determinants of health*.

2 Historical overview

2.1 Roots of a social approach to health

The recognition that social and environmental factors decisively influence people's health is ancient. The sanitary campaigns of the 19th century and much of the work of the founding fathers of modern public health reflected awareness of the powerful relationship between people's social position, their living conditions and their health outcomes. Recent epidemiological research has confirmed the centrality of social and environmental factors in the major population health improvements registered in industrialized countries beginning in the early 19th century. McKeown's analyses revealed that most of the substantial modern reduction in mortality from infectious diseases such as tuberculosis took place prior to the development of effective medical therapies. Instead, the main driving forces behind mortality reduction were changes in food supplies and living conditions¹⁰.

The Constitution of the World Health Organization, drafted in 1946, shows that the Organization's founders intended for WHO to address the social roots of health problems, as well as the challenges of delivering effective curative medical care. The Constitution famously defines health as "a state of complete physical, mental and *social* well-being"

"Do we not always find the diseases of the populace traceable to defects in society?"⁹

Rudolf Virchow (1821-1902)

(emphasis added), identifying the Organization's goal as "the attainment by all peoples of the highest possible level" of this state¹¹. The Organization's core functions include working with Member States and appropriate specialized agencies "to promote ... the improvement of nutrition, housing, sanitation, recreation, economic or working conditions and other aspects of environmental hygiene," as required to achieve health progress. WHO's Constitution thus foresees a supportive integration of biomedical/technological and social approaches to health, though this unity has often come unravelled during the Organization's subsequent history¹².

2.2 The 1950s: emphasis on technology and disease-specific campaigns

The WHO Constitution provided space for a social model of health linked to broad human rights commitments. However, the post-World War II context of Cold War politics and decolonization hampered the implementation of this vision and favoured an approach based more on health technologies delivered through campaigns bearing a "militaristic" imprint¹³. Several historical factors promoted this pattern. One was the series of major drug research breakthroughs that produced an array of new antibiotics, vaccines and other medicines in this period, inspiring health professionals and the general public with the sense that technology held the answer to the world's health problems. This boom also propelled the rise of the modern pharmaceutical industry, destined to become not only a source of scientific benefits but also a political force whose lobbying power would increasingly influence national and international health policy. Another key change in the political context was the temporary withdrawal of the Soviet Union and other communist countries

from the United Nations and UN agencies in 1949. Following the Soviet pullout, UN agencies, including WHO, came more strongly under the influence of the United States. Despite the key US role in shaping the WHO Constitution, US officials were at that time reluctant to emphasize a social model of health whose ideological overtones were unwelcome in the Cold War setting.

During this period and subsequently, health care models in the developing world were influenced by the dynamics of colonialism. The health systems established in areas of Africa and Asia colonized by European powers catered almost exclusively to colonizing elites and focused on high-technology curative care in a handful of urban hospitals. There was little concern for broader public health and few services for people living in slums or rural areas. Many former colonies gained independence in the 1950s and 60s and established their own national health systems. Unfortunately these were often patterned on the models that had existed under colonial rule. On paper, post-independence health strategies often acknowledged the need to extend services to rural and disadvantaged populations, but in practice the bulk of government and international donor funding for health continued to flow to urban-based curative care. During this period, some newly independent low-income countries spent over half their national health budgets maintaining one or two gleaming “disease palaces” – high-tech hospitals stocked with the latest equipment, staffed by western-trained doctors and catering to the health needs of the urban elite¹⁴.

International public health during this period was characterized by the proliferation of “vertical” programmes – narrowly focused, technology-driven campaigns targeting specific diseases such as malaria, smallpox, TB and yaws. Such programmes were seen as highly efficient and in some cases offered the advantage of easily measurable targets (number of vaccinations delivered, etc.). Yet by their nature they tended to ignore the social context and its role in producing well-being or disease. Like hospital-centred health care, they tended to leave the most serious health challenges of the bulk of the population (particularly the rural poor) unaddressed. The vertical campaigns begun in this period generated a few notable successes, most famously the eradication of smallpox. However, the limitations of this approach were revealed by failures like the WHO-UNICEF campaign for the global elimination of malaria. The malaria campaign,

begun in the mid-1950s, relied once again on technology – in this case the wide spraying of the insecticide DDT to kill mosquito vectors. The massive programme proved to be a costly failure¹⁵.

2.3 The 1960s and early 70s: the rise of community-based approaches

By the mid-1960s, it was clear in many parts of the world that the dominant medical and public health models were not meeting the most urgent needs of poor and disadvantaged populations (the majority of people in developing countries). Out of necessity, local communities and health care workers searched for alternatives to vertical disease campaigns and the emphasis on urban-based curative care. A renewed concern with the social, economic and political dimensions of health emerged.

During the 1960s and early 70s, health workers and community organizers in a number of countries joined forces to pioneer what became known as community-based health programmes (CBHP)¹⁴. Such initiatives emphasized grassroots participation and community empowerment in health decision-making and often situated their efforts within a human rights framework that related health to broader economic, social, political and environmental demands. The importance of high-end medical technology was downplayed, and reliance on highly trained medical professionals was minimized. Instead, it was thought that locally recruited community health workers could, with limited training, assist their neighbours in confronting the majority of common health problems. Health education and disease prevention were at the heart of these strategies.

China’s rural health workers (figuratively referred to as “barefoot doctors”) were the most famous example. These were “a diverse array of village health workers who lived in the communities they served, stressed rural rather than urban health care, preventive rather than curative services, and combined western and traditional medicines”¹⁶. Community-based initiatives also flourished in Bangladesh, Costa Rica, Guatemala, India, Mexico, Nicaragua, the Philippines, South Africa and other countries. In some instances, such initiatives engaged directly not only with social and environmental determinants of health, but with underlying issues of political-economic

structures and power relations. In some parts of Latin America, Brazilian educator Paulo Freire's awareness-raising methods were adapted to health education and promotion. In the Philippines, some groups practiced community-based "structural analysis" through which community members traced the social and political roots of their health problems. "These methodologies for empowerment became tools in helping groups of disadvantaged people conduct a 'community diagnosis' of their health problems, analyze the multiplicity of causes and plan strategic remedial actions" in innovative ways¹⁴. In Central America, South Africa and the Philippines, loose alliances of community-based health programmes gradually grew into social movements linking health, social justice and human rights agendas. Werner and Sanders argue that in several cases (the overthrow of the Somoza dictatorship in Nicaragua, resistance to the South African apartheid regime and the weakening and eventual toppling of Ferdinand Marcos' authoritarian government in the Philippines), community-based health movements helped lay the groundwork for political change and the eventual reversal of despotic regimes¹⁴. Reciprocally, Cueto argues, anti-imperialist movements in many developing countries and a weakening of US prestige as a result of setbacks in Viet Nam helped create favourable conditions for the global uptake of these alternative health models during the late 1960s¹⁶.

What had begun as independent, local or national CBHP experiments acquired a growing international profile and a cumulative authority in the early 1970s. Some NGOs and international missionary organizations, in particular the Christian Medical Commission, played an important role in promoting community-based models on the ground and disseminating information on their success¹⁷. By the early 1970s, awareness was growing that technologically driven approaches to health care had failed to significantly improve population health in many developing countries, while results were being obtained in some very poor settings through community-based programs. Some leading scholars, international public health planners and development experts began to advocate broad adoption of an approach to health informed by the practices and priorities of CBHP. This included leaders at WHO. In 1975, WHO's Kenneth Newell, Director of the Organization's Division of Strengthening Health Services, published *Health by the People*, which presented success stories from a series of community-based health initiatives

in Africa, Asia and Latin America. The book advocated a robust engagement with the social dimensions of health, arguing that:

*"We have studies demonstrating that many of the 'causes' of common health problems derive from parts of society itself and that a strict health sectoral approach is ineffective, other actions outside the field of health perhaps having greater health effects than strictly health interventions"*¹⁸.

Newell (1975)

In the same year, WHO and UNICEF published a joint report examining *Alternative approaches to meeting basic health needs in developing countries*. The report underscored the shortcomings of vertical disease programmes that relied on technological fixes and ignored community ownership. It emphasized that social factors such as poverty, inadequate housing and lack of education were the real roots underlying the proximal causes of morbidity in developing countries¹⁹.

This emerging model of health work found a powerful champion in Halfdan Mahler, a Danish physician and public health veteran who became Director-General of WHO in 1973. Mahler was a charismatic leader with deep moral convictions, for whom "social justice was a holy word"²⁰. He was angered at global inequities in health and at the avoidable suffering undergone by millions of poor and marginalized people. Having participated in vertical disease campaigns in Latin America and Asia, Mahler was convinced that such approaches were incapable of resolving the most important health problems, and that an excessive focus on advanced curative technologies was distorting many developing countries' health systems. Hand in hand with the expansion of basic health care services to disadvantaged communities, action to address non-medical determinants was necessary to overcome health inequalities and achieve "Health for All by the year 2000", as Mahler proposed at the 1976 World Health Assembly. "Health for all," he 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”²¹.

2.4 The crystallization of a movement: Alma-Ata and primary health care

This new agenda took centre stage at the International Conference on Primary Health Care, sponsored by WHO and UNICEF at Alma-Ata, Kazakhstan, in September 1978. 3,000 delegates from 134 governments and 67 international organizations participated in the Alma-Ata conference, destined to become a milestone in modern public health. The conference declaration embraced Mahler’s goal of “Health for All by the Year 2000”, with primary health care (PHC) as the means. The adoption of the HFA/PHC strategy marked a forceful re-emergence of social determinants as a major public health concern. The PHC model as articulated at Alma-Ata “explicitly stated the need for a comprehensive health strategy that not only provided health services but also addressed the underlying *social, economic and political causes of poor health*” (original emphasis)¹⁴.

Many elements of the PHC approach were shaped by the Chinese “barefoot doctors” model and other community-based health experiences accumulated over the previous decade. The Alma-Ata declaration presented PHC in a double light. On the one hand, as the fundamental level of care within a health system reconfigured to emphasize the basic health needs of the majority, PHC was “the first level of contact of individuals, the family and community with the national health system”²². But PHC was also a *philosophy* of health work as part of the “overall social and economic development of the community”²². Cueto identifies three salient principles of the PHC philosophy. The first was “appropriate technology”: i.e., the commitment to shift health resources from urban hospitals to meeting the basic needs of rural and disadvantaged populations. The second was a “critique of medical elitism,” implying reduced reliance on highly specialized doctors and nurses and greater mobilization of community members to take responsibilities in health work. The third core component of PHC was an explicit linkage between health and social development. “Health work was perceived not as an isolated and short-lived intervention but as part of a process of

improvement of living conditions”¹⁶. Logically, PHC included among its pillars intersectoral action to address social and environmental health determinants. The Alma-Ata declaration specified that PHC “involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communication, and other sectors; and demands the coordinated efforts of all these sectors”.

Under Mahler’s leadership, WHO reconfigured its organizational profile and a significant part of its programming around Health for All through PHC. Accordingly, health work under the HFA banner regularly incorporated, at least on paper, intersectoral action to address social and environmental determinants. During the 1980s, as the drive towards HFA unfolded, the concept of intersectoral action for health (IAH) took on increasing prominence, and a special unit was created within WHO to address this theme. In 1986, WHO and the Rockefeller Foundation co-sponsored a major consultation on IAH at the latter’s Bellagio conference facility²³, and technical discussions on IAH were held at the 39th World Health Assembly. The WHA discussions included working groups on health inequalities; agriculture, food and nutrition; education, culture, information and lifestyles; and the environment, including water and sanitation, habitat and industry²⁴.

From the mid-1980s, SDH were also given prominence in the emerging health promotion movement. The First International Conference on Health Promotion – cosponsored by the Canadian Public Health Association, Canada’s Health and Welfare department and WHO – was held in Ottawa in November 1986. The conference adopted the Ottawa Charter on Health Promotion, which identified eight key determinants (“prerequisites”) of health: peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice, and equity. It was understood that this broad range of fundamental enabling factors could not be addressed by the health sector alone, but would require coordinated action among different government departments, as well as among nongovernmental and voluntary organizations, the private sector and the media²⁵. Following Ottawa, a series of international health promotion conferences developed the messages contained in the charter and sought to build a sustained movement²⁶.

2.5 In the wake of Alma-Ata: “Good health at low cost”

The years following the Alma-Ata conference were not generally favourable for health progress among poor and marginalized communities, for reasons to be examined shortly. However, a number of developing countries emerged as models of good practice during this period. They were able to improve their health indicators and strengthen equity, through programmes in which intersectoral action on health determinants played an important role.

“Good health at low cost” (GHLC) was the title of a conference sponsored by the Rockefeller Foundation in April-May 1985. The published proceedings became an important reference in debates about how to foster sustainable health improvements in the developing world²⁷. The conference closely examined the cases of three countries (China, Costa Rica and Sri Lanka) and one Indian state (Kerala) that had succeeded in obtaining unusually good health results (as measured by life expectancy and child mortality figures), despite low GDP and modest per capita health expenditures, relative to high-income countries.

Costa Rica

In 1988 the Pan-American Health Organization characterized Costa Rica as a “developing non-industrial nation with health indicators comparable to those registered a few years ago by some advanced industrial nations”²⁸. Between 1970 and 1983, the country cut general mortality by 40 percent, and infant mortality was reduced by 70 percent²⁹.

Commitment to nationwide coverage in health care and key basic social services contributed crucially to this pattern. A 1971 law guaranteed medical care and hospitalization coverage under social security for the entire population. Regardless of salary level, all workers became affiliated with social security benefits provided through the *Caja Costarricense del Seguro Social* (Costa Rican Social Security Fund, or CCSS), funded through state resources and compulsory contributions from workers. The CCSS was one of a range of policy instruments based on principles of national solidarity and coverage for the very poor. The CCSS drove several broad public health interventions: immunization campaigns were intensified against diseases such as measles and diphtheria; the provision of potable water and sewage disposal were expanded, especially in rural areas. The two-thirds decline in infant mortality in the 1970s appears to have been due to Costa Rica’s multi-pronged strategy simultaneously tackling a range of medical, infrastructural and social factors³⁰.

The Rural Health Program (RHP), launched in 1973, and the urban Community Health Program of 1976 delivered robust, multifaceted primary health care. Taken together, these programs expanded access to medical services to approximately 60 percent of the population – both urban and rural – by 1980³⁰. At the outset of the CCSS, less than 20 percent of the rural population had access to minimal health services³¹. The RHP identified areas of greatest need and trained community health workers to visit homes in their respective areas in order to improve health practices, sanitation and vaccination of children. At its core was a primary health care approach which provided a broad range of services to individuals (e.g., vaccination, nutrition, family planning, and dental care); environmental health activities (e.g., potable drinking water, improvement of rural housing, excreta elimination); and complementary supporting services (e.g., health education, data collection and promoting community organization)²⁹. The RHP significantly expanded services so that by the end of the 1970s, health services covered more than 60 percent of the rural population while all health indicators improved significantly nationwide^{29,31}. The urban Community Health Program, patterned after the RHP, aimed to improve the living conditions of slum dwellers. Within three years of its creation in 1976, the program reached 57 percent of the urban population. By the end of the decade, this initiative has succeeded in expanding vaccination to 85-90 percent of urban population, feces disposal in urban areas had increased from 60 to 96 percent and 100 percent of the urban population had access to potable water²⁹.

Analysts of the country’s success have underscored Costa Rica’s strong policy link between health and education. Knowledge about health is regarded as an essential part of education at all levels, and the education system has consciously been used as a venue through which to promote good health. The free and compulsory grammar school system, operational since 1869, was expanded to include free middle school and a strengthening of the university system in 1949. Due to the expansion of children’s school during the 1940s and 1950s, the proportion of women who completed primary school increased from 17 percent in 1960 to 65 percent in 1980. This trend appears to have been a driver of the substantial decline in infant mortality during the 1970s³⁰.

The GHLC cases are still frequently cited when analysts wish to give examples of health progress in developing countries, and in particular to show how policy in non-health sectors can improve health status. The question of which factors contributed most to these jurisdictions' success has continued to concern analysts – along with the corollary problem of why it has been so difficult for other countries at similar income levels to replicate their achievements. A generation later, the issues raised in *Good health at low cost* remain relevant, and it is well worth looking in greater depth at

some of the strategies pursued by GHLC countries which contributed to their status as good practice models. In what follows, we look at two GHLC jurisdictions and a third country, Cuba, which was not included in the study, but had pursued similar public health policies. Our particular aim is to see how these countries used intersectoral policies addressing health determinants as key tools for improving population health indicators and in particular meeting the needs of vulnerable population groups.

Sri Lanka

Sri Lanka achieved strong improvements in health indicators following independence in 1948, despite the country's failure to generate sustained economic growth³². An expansive primary health care system provided free to the entire population contributed significantly to population health gains³³. At the same time, pro-equity strategies across several social sectors played a major role in improving health outcomes³².

In agriculture, self-sufficiency in rice production and other essential food stuffs was a priority for the newly independent nation. "The agricultural strategy of succeeding governments ... diversified peasant agriculture with high-yielding crops, increased overall production and boosted the incomes of farmers". By the early 1980s, this program had reduced regional and class disparities, providing relief for some of the poorest groups, such as the rice-growing peasantry, as part of a national effort to meet "basic needs" across the whole population. Over several decades, a food rationing scheme ensured the supply of rice and several other essential food items at subsidized or stable prices to all households through a network of cooperatives. As a result, between 1956 and 1963, the average caloric intake of the population as a whole increased by 40 percent³². Simultaneous efforts to increase and improve the rural housing stock led to better structure, design and quality of rural housing³⁴. Meanwhile, the health and well-being of workers, particularly women and youth, were addressed through a series of labour laws in the 1950s. These included provisions to limit the work week to 45 hours and to provide annual compulsory vacation and sick leave with pay. The extension of an affordable public transportation network of rail and road services increased the rural population's access to basic health care services. In 1978, 70 percent of births in Sri Lanka took place to hospitals, clinics and maternity homes³².

Universal free education has been provided since independence through a network of primary, secondary and tertiary educational institutions. By 1980, health education and physical activity were included in the school curriculum. From 1945 onward, all students were provided with a free mid-day meal. A large expansion in female education in the 1950s and 1960s virtually eradicated literacy differences between males and females and led to a wide acceptance of family planning and a decline in the birth rate from the early 1960s³².

Analysts found that this whole range of intersectoral actions was facilitated by the country's political system and culture of civil society participation. The competitive political environment in Sri Lanka enabled the poor rural majority to secure a considerable degree of redistribution and social welfare benefits. Women became active in the political process even before national independence, forcing the political elite to respond to their concerns. The high priority accorded to maternal and child health in the 1930s and 1940s was a result. The popularity of political leaders, particularly in the two decades prior to independence, was based upon their capacity to secure a wide range of state services for the electorate, among which health and education assumed a high priority. A large and active non-governmental sector pressed political, economic and health concerns effectively. Groups including village-level rural development societies and women's associations were active in initiating public health campaigns, such as the anti-TB campaign³⁴.

Cuba

Post-revolutionary Cuba constituted an important example of “good health at low cost” that did not make it onto the agenda of the 1985 conference. Cuba’s population health profile more closely resembles wealthy countries like the US and Canada than most other Latin American countries³⁵. While Cuba had likely attained one of the most favourable mortality levels in the developing world by the end of the 1950s, further significant declines in mortality took place following the socialist revolution of 1959. The revolution brought medical and public-health resources within the reach of formerly marginalized sectors of society. By redirecting national wealth towards the fulfilment of basic needs, the standard of living for the more disadvantaged social groups was improved despite the country’s faltering economic performance in the 1960s and 1970s. Rural-urban differences in health and its social determinants were reduced as the state invested more national resources in rural areas³⁶. In 1959 the country’s infant mortality rate was 60/1000 live births and life expectancy was 65.1 years. By the mid-1980s Cuba had attained an infant mortality rate of 15/1000 and female life expectancy of 76 years³⁷.

The principles of universality, equitable access and governmental control guided post-revolutionary Cuban health policies, which focussed on achieving social equity through free provision of needed services, including medical care, diagnostic tests and vaccines for 13 preventable diseases. Cuba’s public health policy prioritizes health promotion and disease prevention activities, decentralization, intersectoral action and community participation; it features a local primary care approach which exists within an organized system of consultation and referral for more specialized care. At local level, physicians and nurses live within the community they serve and provide not only clinical diagnosis and treatment, but also community education about general health issues and non-medical health determinants³⁵.

Cuba has made progress in addressing the social determinants of health, applying the same basic principles of universality, equitable access and government control. Education has been a national priority. The government launched massive literacy campaigns shortly after the revolution, nationalizing all private schools and making education free and universal. Subsequently, programmes to ensure that every adult obtained at least a sixth grade education were put in place³⁶. Cuba’s literacy rate is 96.7 percent, remarkable considering that before the revolution, one quarter of Cubans were illiterate and another tenth were semiliterate³⁵. The post-revolutionary period also saw campaigns to improve standards of hygiene and sanitation in urban areas by increasing access to potable water through expansion of the network of aqueducts^{35,36}. From early on, discussion of post-revolutionary Cuba’s health and social policies bore an ideological and polemical stamp. Critics of the Cuban system pointed to restrictions on individual rights and a generalized economic stagnation under the socialist regime. Defenders argued that Cuba’s commitment to social equity and universal primary health care enabled the country to limit the health damage associated with prolonged economic embargo³⁸.

While the GHLC jurisdictions and countries like Cuba exhibited a range of different political frameworks and public health strategies, *Good health at low cost* argued that it was possible to discern elements of a common pattern among developing countries that had made exceptional health progress.

In the area of IAH, the most crucial areas appeared to be: (1) guaranteeing an adequate food intake for all, including the most socially vulnerable groups, and (2) women’s education. The theme of women’s education/literacy as a health determinant subsequently provided the rationale for health promotion campaigns in several developing countries⁴⁰.

Five shared social and political factors making “good health at low cost” possible³⁹

- **Historical commitment to health as a social goal**
- **Social welfare orientation to development**
- **Community participation in decision-making processes relative to health**
- **Universal coverage of health services for all social groups (equity)**
- **Intersectoral linkages for health.**

Ironically, by the time *Good health at low cost* was published, several of the jurisdictions studied – including Costa Rica and Sri Lanka – were being affected by global economic and political changes that would threaten the population health achievements praised in the volume (see below). Subsequent decades revealed the vulnerability to external shocks and domestic political vicissitudes of some of the policies that had enabled these countries to become models for improving population health and health equity.

The message of GHLC was both encouraging and deeply challenging for health policy makers in developing countries⁴¹. On the one hand, the study confirmed that impressive health gains were possible in countries with relatively low GDP per capita. But on the other hand, the enabling

social and political conditions that appeared to have made GHLC countries' success possible were precisely, as the above list suggests, conditions that the majority of developing countries did not and perhaps could not fulfil. Many of these countries lacked a historical commitment to health as a social goal; a tradition of democratic community participation; and equity in health services coverage (or even the serious political will to strive for it). Few countries' development policies could realistically be described as oriented towards broadly shared social welfare.

Thus, of the five social and political factors found by Rosenfield to be common to GHLC countries and to explain their success, the one seemingly most easily within reach for developing country policymakers was the last: intersectoral linkages for action on health determinants. Accordingly, a formal commitment to IAH became part of many countries' official health policy frameworks in the 1980s. However, the track record of actual results from national implementation of IAH was feeble. Indeed, despite the high profile accorded to intersectoral action in the Alma-Ata Declaration, WHA technical discussions, the health promotion movement and *Good health at low cost*, IAH to address social and environmental health determinants generally proved, in practice, to be the weakest component of the strategies associated with Health for All⁴².

Why? In part, precisely because many countries attempted to implement IAH in isolation from the other relevant social and political factors pointed out in the above list. These contributing factors are to an important degree interdependent and mutually reinforcing. Thus, the chances of success in IAH vary with the strength of the other pillars: broad commitment to health as a collective social and political goal; the crafting of economic development policies to promote social welfare; community empowerment and participation; and equity in health services coverage. Where these objectives were not seriously pursued, IAH also faltered.

Later analysts identified further reasons why IAH failed to "take off" in many countries in the wake of Alma-Ata and GHLC. One problem concerned evidence and measurement. Decision-makers in other sectors complained that health experts were often unable to provide quantitative evidence on the specific health impacts attributable to activities in non-health sectors such as housing, transport, education, food policy or industrial policy⁴². At

a deeper level, beyond the inability to furnish data in specific cases, profound methodological uncertainty persisted about how to measure social conditions and processes and accurately evaluate their health effects. The problem was complicated both by the inherent complexity of such processes and by the frequent time-lag between the introduction of social policies and the observation of effects in population health. Measurement experts reached no clear resolution on the methodological challenges of evaluation and attribution in social contexts where by definition the conditions of controlled clinical trials could not be approximated.

During the 1980s, IAH also ran up against government structures and budgeting processes poorly adapted to intersectoral approaches. One review identified the following difficulties:

- ❖ Vertical boundaries between sections in government
- ❖ Integrated programmes often seen as threatening to sector-specific budgets, to the direct access of sectors to donors, and to sectors' functional autonomy
- ❖ Weak position of health and environment sectors within many governments
- ❖ Few economic incentives to support intersectorality and integrated initiatives
- ❖ Government priorities often defined by political expediency, rather than rational analysis⁴³.

Uncertainties about evidence and intra-governmental dynamics were only part of the problem, however. Wider trends in the global health and development policy environment contributed to derailing efforts to implement intersectoral health policies. A decisive factor was the rapid shift on the part of many donor agencies, international health authorities and countries from the ambitious Alma-Ata vision of primary health care, which had included intersectoral action on SDH as a core focus, to a narrower model of "selective primary health care".

2.6 The rise of selective primary health care

From early on, both the potential costs and the political implications of a full-blown version of PHC were alarming to some constituencies. Selective PHC was rapidly proposed in the wake of the Alma-Ata conference as a more pragmatic, financially palatable and politically unthreatening

alternative^{14,44}. Rather than trying to strengthen all aspects of health systems simultaneously or to transform social and political power relations (a possibly laudable but necessarily long-term objective), advocates of selective PHC maintained that, at least in the short term, efforts should concentrate on a small number of cost-effective interventions aimed to attack a country's or region's major sources of mortality and morbidity. Selective PHC in effect eliminated the social and political dimensions of the original PHC vision. The theorists of selective PHC presented it as an "interim" strategy to be implemented urgently while countries worked to marshal the more considerable resources and political commitment needed for comprehensive PHC⁴⁴. In many settings, however, the interim model effectively suppressed comprehensive PHC as a long-term objective.

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 immunization. By concentrating on 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 necessarily lengthy processes of health systems strengthening (or a fortiori for structural social change). The four GOBI interventions "appeared easy to monitor and evaluate. Moreover, they were measurable and had clear targets". It was foreseen that this model would appeal to potential funders, as well as to political leaders eager for quick results, since "indicators of success and accounts could be produced more rapidly" than with the sorts of complex social processes associated with comprehensive PHC¹⁶.

The GOBI strategy became the centrepiece of the "child survival revolution" promoted by UNICEF in the 1980s⁴⁵. Under its earlier Executive Director Henry Labouisse, UNICEF had cosponsored the Alma-Ata conference and supported much of the early groundwork for the original PHC strategy. The arrival of Jim Grant at the head of the agency in 1979 (the year after Alma-Ata) signalled a fundamental shift in UNICEF's philosophy. Like Halfdan Mahler, Grant was a charismatic leader. But where Mahler

was convinced international organizations had a mission of moral leadership for social justice, Grant believed international agencies "had to do their best with finite resources and short-lived political opportunities", working within existing political constraints, rather than succumbing to utopian visions. This meant renouncing ambitions of broad social transformation to concentrate on narrow but feasible interventions¹⁶. This tightly focused, pragmatic approach was embodied in the GOBI strategy.

GOBI proved effective in many settings in cutting child mortality. However, it constituted a dramatic retreat from the original Alma-Ata vision, particularly regarding intersectoral action on social and environmental health determinants. Additional components with a more multisectoral character (family planning, female education and food supplementation) were added later, on paper, to the original GOBI interventions, but these additional ideas were ignored in many places. Indeed, in actual practice the GOBI strategy was even narrower than the acronym implied, since many countries restricted their child survival campaigns to oral rehydration therapy and immunization¹⁴. The narrow selection of interventions targeted primarily at women of childbearing age and children under 5 "was designed to improve health statistics, but it abandoned Alma-Ata's focus on social equity and health systems development"³⁸.

The fate of the Health for All effort and the implications of the shift from comprehensive to selective PHC have generated a substantial and often polemical literature^{14,46,47,48,49}. For critics of selective PHC, including recently Magnussen et al.: "the selective approach ignores the broader context of development and the values that are imbued in the equitable development of countries. It does not address health as more than the absence of disease; as a state of well-being, including dignity; and as embodying the ability to be a functioning member of society. In conjunction with the lack of a development context, the selective model does not acknowledge the role of social equity and social justice for the recipients of technologically driven medical interventions"³⁸. Cueto summarizes that, for its critics, SPHC was a "narrowly technocentric" strategy that turned away from the underlying social determinants of health, ignored the development context and its political complexities, and resembled vertical programmes¹⁶.

On the other hand, defenders of the selective approach object that comprehensive PHC and the Alma-Ata vision as a whole, while draped in moral language to which no one can object, were from the start technically vague and financially unrealistic, hence impossible to implement. The multiple meanings of the term “primary health care” undermined its power. As Cueto observes: “In its more radical version, PHC was adjunct to a social revolution. For some this was negative and Mahler was to be blamed for transforming WHO from a technical into a politicized organization”. Others believed Mahler was “naïve to expect changes from the conservative bureaucracies of developing countries”, and that he far overestimated the capacity of a small number of enlightened experts and bottom-up community health projects to effect lasting social change. Meanwhile the deep political marginalization and impotence of the rural poor were not sufficiently understood by PHC advocates. Likewise, defenders of the Alma-Ata vision tended to romanticize and idealize “communities” in the abstract, with too little attention to their actual functioning¹⁶.

These debates have implications that reach far beyond the specific historical context of the 1980s to raise questions of relevance today – including for the Commission on Social Determinants of Health. Arguably, both the great strength and the fatal weakness of comprehensive PHC stemmed from the fact that it was much more than a model for delivering health care services. PHC and Health for All as presented at Alma-Ata constituted a far reaching project of social transformation, guided by an ideal of the empowerment of disadvantaged people and communities, under a model of “development in the spirit of social justice”²². With such values at stake, it is hardly surprising that impassioned debates on the meaning and legacy of Health for All continue today. A question with which the CSDH must grapple is a version of the problem embodied in the emblematic figures of Mahler and Grant. Whether to focus on highly charged concepts like social justice or less strong (but also less threatening) ones like equity or efficiency. The choice is not only about language but implies different levels of engagement with political processes and quite different proposals for action.

The emergence of selective PHC as an alternative to the Alma-Ata vision in the early 1980s was not accidental. Rather, it was the logical reflection of a broader shift in political power relations and

economic doctrines occurring at global level. This shift had significant consequences for health, and in particular for the capacity of governments to craft health policies addressing social determinants. To fully understand the failures of intersectoral action on SDH (and the Alma-Ata strategy as a whole), we must situate the “PHC vs. SPHC” problem within this broader context.

2.7 The political-economic context of the 1980s: neoliberalism

The 1980s saw the rise to dominance of the economic and political model known as “neoliberalism” (for its emphasis on “liberalizing” or freeing markets) or the “Washington consensus” (since its main proponents – the US government, the World Bank and the International Monetary Fund – are based in Washington, DC). The historical origins and evolution of the neoliberal model have been discussed in detail elsewhere^{50,51}. The core of the neoliberal 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 health⁵⁰. Government involvement in the economy and in social processes should be minimized, since state-led processes are inherently wasteful, cumbersome and averse to innovation. “The welfare state, in the neoliberal view, interferes with the ‘normal’ functioning of the market” and thus inevitably wastes resources and delivers unsatisfactory results⁵⁰. Logically, an overarching goal of policy must be to reduce the role of the state in key areas (including health) where its presence leads to inefficiencies. Instead, maximum freedom must be accorded to market actors whose pursuit of their own interests will most rapidly generate economic growth and create wealth – the key preconditions for improved well-being for all. Better than any form of state-managed redistribution, market processes themselves can be trusted to distribute the benefits of economic growth through all levels of society. A key postulate of the neoliberal economic orthodoxy of the 1980s and 90s was that, since economic growth was the key to rapid development and ultimately to a better life for all, countries should rapidly and rigorously implement policies to stimulate growth, with little concern for the social consequences in the near term. While growth-enhancing policies such as cuts to government social spending might involve

“short-term pain” for disadvantaged communities, this would be more than compensated by the “long-term gain” such policies would produce by creating a favourable investment climate and accelerating economic development.

During the 1980s, the neoliberal view was successfully promoted domestically in wealthy countries by such leaders as Ronald Reagan in the USA, Margaret Thatcher in Great Britain and Germany’s Helmut Kohl. In the international development field, neoliberalism was imposed by donor governments via bilateral programmes, but most importantly through the activities of the World Bank and International Monetary Fund. The prolonged global economic recession of the 1980s and the associated debt crisis in the developing world pushed many low and middle-income countries to the brink of economic collapse. These events provided the context in which powerful northern governments and the international financial institutions (IFIs) could intervene directly in the economies of numerous developing countries, requiring that such countries reshape their economies according to neoliberal prescriptions in order to qualify for debt rescheduling and continued aid⁵¹.

Neoliberal doctrines affected health through two main mechanisms: (1) the health sector reforms undertaken by many low and middle-income countries beginning in the 1980s; and (2) the broader economic structural adjustment programmes imposed on a large number of countries as a condition for debt restructuring, access to new development loans and other forms of international support. To these instruments for the propagation of the neoliberal paradigm was added a third device, of particular importance from the mid-1990s onward: international trade agreements and the rules established by bodies such as the World Trade Organization (WTO), formed in 1995.

The neoliberal health sector reforms (HSR) of the 1980s and 90s aimed to address structural problems in health systems, including: the need to place limits on health sector expenditures and to use resources more efficiently; poor systems management; inadequate access to services for poor people, despite the rhetoric of PHC; and poor quality of services in many countries and regions^{52,53}. Unfortunately, in many instances the reforms undertaken failed to remedy these problems and in some cases actually made them worse. While proponents of the reforms acknowledged that they

should be “context sensitive”, in practice HSR tended to adopt a limited menu of measures assumed to be valid everywhere⁵³. Features of the HSR agenda included:

- ❖ Increasing the private sector presence in the health sector, through strategies such as encouraging private options for financing and delivery of health services and contracting out
- ❖ Separation of financing, purchasing and service provision functions
- ❖ Decentralization (often without adequate regulatory and stewardship mechanisms at the sub-national levels to which responsibility was devolved)
- ❖ Focusing on efficiency (and not equity) as the primary performance criterion for national health authorities, while at the same time cutting human and financial resources to the health sector, so that the exercise of efficient stewardship became increasingly difficult in practice

The effectiveness of HDR measures has been widely debated, but evidence of negative impacts has emerged from many settings. In many countries, government stewardship capacities in health were weakened as a result of reform. A recent review of HSR in Latin America concludes that the reforms failed to achieve their officially stated objectives of improving health care and reducing health inequity; indeed many HSR processes “caused the opposite results: increased inequity, less efficiency and higher dissatisfaction, without improving quality of care”⁵⁴. On the other hand, the reforms attained unofficial objectives that may have been more important. Decentralization enabled central governments to “offload” health sector costs to regional, state and local authorities and to use the resulting savings at national level to continue repaying foreign debts. Privatization created lucrative opportunities for US-based HMOs and private health insurance companies anxious to penetrate Latin American markets.

Processes in Africa and Asia encountered different obstacles, but generally brought similarly unsatisfactory results. A detailed comparative study of HSR processes in Ghana, India, Sri Lanka and Zimbabwe concluded that reform packages were “inappropriately designed for developing country contexts” and “quite out of touch with the reality of [countries’] health systems and the broader socio-political environment”; meanwhile, “the political feasibility of the reforms was highly

questionable, especially in Asian countries⁵⁵. The faith in the inherently beneficial effects of market dynamics which underlay reform proposals was misplaced in developing countries with relatively weak regulatory and administrative capacities.

In reality “the current state must have even more strengths and abilities than its archaic predecessors, if it is going to capitalize on the virtuous efficiencies of the marketplace without suffering the latter’s side effects”, including negative impacts on equity⁶⁶.

The same assumptions shaping HSR processes were “writ large” in the macroeconomic structural adjustment programmes (SAPs) implemented by many countries in Africa, Asia and Latin America under the guidance of the IFIs. SAPs typically included the following components: liberalization of trade policies (through elimination of tariffs and other restrictions on imports); privatization of public services and state enterprises; devaluation of the national currency; and a shift from production of food and commodities for domestic consumption to production of goods for export^{14,51}.

To understand the implications of neoliberal economic models for efforts to address SDH, it is important to recall the impact of structural adjustment packages on many countries’ social sector spending. A central principle of SAPs was sharp reduction in government expenditures, in many cases meaning drastic cuts in social sector budgets. These cuts affected areas of key importance as determinants of health, including education, nutrition programmes, water and sanitation, transport, housing and various forms of social protection and safety nets, in addition to direct spending in the health sector. With sharply falling public sector budgets, not only could new investment not be seriously envisaged to address social and environmental factors influencing health, but already existing supports were shorn away. Food subsidies, for example, were slashed in many countries, while price controls on staple goods were lifted. In addition, many SAPs demanded large and abrupt cuts in public

sector payrolls. The sudden layoffs propelled huge numbers of people into unemployment, with no safety nets and little chance of finding formal work in the private sector in many cases. The negative health effects for individuals, families and whole communities have been documented. In some countries, particularly in southern Africa, the resulting social destabilization and insecurity contributed to hunger, the propagation of armed conflict and the rapid spread of HIV/AIDS – with the poor, women and other socially disadvantaged groups bearing the brunt of the damage⁵⁷.

As a result of SAPs and the global economic malaise, social sector spending in many countries plummeted during the 1980s, with negative effects on the health status of vulnerable communities. In the poorest 37 countries in the world, public spending on education dropped by 25% in the 1980s, while public spending on health fell 50%⁵⁸. Since SAPs were implemented at the cost of great human suffering, one would assume that their track record in delivering enhanced economic growth, their official *raison d’être*, must be impressive. Unfortunately this is not the case. Many of the low-income countries that implemented SAPs, particularly in Africa, saw little if any improvement in their GDP growth rate or other core economic indicators following adjustment. Thus the “short-term pain” the programmes brought was much worse than the international financial institutions had predicted, while the promised “long-term gain” failed to materialize in many cases^{14,51}.

2.8 The 1990s and beyond: contested paradigms and shifting power relations

2.8.1 Debates on development and globalization

Neoliberal economic prescriptions continued to be widely applied through the 1990s. However, as the decade advanced, these models were called increasingly into question, in developing countries and by a growing number of international agencies and constituencies in the global north. The successes and failures of the economic orthodoxy embodied in SAPs were intensely debated; indictments of the IFIs multiplied through the decade^{59,60,61}. Fuel was added to the critiques as countries of the former Soviet bloc began to register the social and health effects of economic “shock therapy” programmes designed to move

these societies rapidly from planned economies to the market system^{62,63}. A series of local and regional economic crises in the course of the decade underscored the volatility of the new economic order and the vulnerability of poor and marginalized people to the economic fluctuations that global actors seemed unable or unwilling to prevent. The resultant critiques fed a growing movement of social and political protest that surged into international headlines when tens of thousands of demonstrators disrupted the meeting of the World Trade Organization in Seattle, USA, in 1999, opening a period in which massive street protests accompanied most major meetings of international financial and trade bodies, as well as fora like the G-8.

The concept of “globalization” was central to these contestations. Protesters and critics denounced the perceived threat of a global economic order dominated by transnational corporations and volatile flows of “hot money”, whose fickle movements could have devastating effects on national economies and the well-being of poor and vulnerable communities. Other commentators emphasized the benefits of progressive economic and technological integration and argued that the dynamism of the liberalized global economy was the key to lifting hundreds of millions of people out of poverty, hunger and despair. Rival visions of what globalization is or should be clashed in the media, scholarly publications, international fora and policymakers’ debates^{64,65,66}.

The international institutions which were prime objects of many of the debates were themselves undergoing changes. Shaken by an unprecedented wave of intellectual criticism and popular anger, the Bretton Woods institutions and entities such as the G-8 began to rethink their respective missions – or at the very least to alter their rhetoric. To grapple more effectively with the debt problems plaguing numerous developing countries, the World Bank and IMF launched the Heavily Indebted Poor Countries (HIPC) initiative in 1996, and followed it with an “enhanced” HIPC programme. The HIPC programmes offered carefully structured forms of debt relief to more than 40 of the poorest countries (the majority in Africa), the gains from which could be largely invested in core social expenditures such as health and education. To further galvanize poverty reduction efforts, the World Bank and IMF introduced Poverty Reduction Strategy Papers (PRSPs) in December 1999 as a “new approach to the challenge of reducing poverty in low-income countries, based

on country-owned poverty reduction strategies that would serve as a framework for development assistance”⁶⁷. The value of the PRSP model continues to be debated. The evidence available so far suggests, however, that PRSPs tend to neglect key issues related to health⁶⁸, while a WHO report in 2002 found no evidence that the PRSP process was leading to significantly increased spending commitments in health and education⁶⁹. A 2003 review of 23 highly-indebted poor countries’ interim PRSPs (iPRSPs) concluded that much remains to be done to integrate appropriate health policies in poverty reduction strategies⁷⁰. A lack of country-specific data on the distribution of disease, the composition of the burden of disease, the prevailing health system constraints and the impact of health services were found in most of the iPRSPs reviewed. Moreover, only a small group of iPRSPs documented efforts to explicitly include the interests of the poor in the design of health policy; in fact, the majority did not take an explicitly pro-poor approach. The attention given to making the distribution of public health expenditures more responsive to the needs of the poor was even more limited.

2.8.2 Mixed signals from WHO

The late 1980s and early 1990s witnessed a waning of WHO’s authority, with de facto leadership in global health seen to shift from WHO to the World Bank. In part this was a result of the Bank’s vastly greater financial resources; by 1990, Bank lending in the population and health sector had surpassed WHO’s total budget⁷¹. In part the shift also reflected the Bank’s elaboration of a comprehensive health policy framework that increasingly set the terms of international debate, even for its opponents. While open to criticism in many respects, the Bank’s health policy model as presented in the 1993 World Development Report *Investing in Health* showed intellectual strength and was coherent with regnant economic and political orthodoxy⁷².

Despite the erosion of WHO’s influence during this period, however, the Organization’s activities present a complex picture; important and forward-looking work was undertaken by many groups within or connected with WHO. Some efforts gave an important place to social and environmental determinants. For example, in certain regions, most clearly Europe, action to address health equity challenges and the social underpinnings of health continued as part of an unbroken commitment to the Health for All ideal. A dedicated WHO Equity Initiative (1995-

98) based at Geneva Headquarters clarified the understanding of health equity as primarily related to people's positions within social hierarchies, and thus to gradients of social, economic and political power^{73,74}. Despite intellectual products of high quality, the momentum of the initiative was broken by personality conflicts and political struggles. The initiative was suspended in 1998.

From 1994 to 1997, WHO sponsored the Task Force on Health in Development, chaired by Brandford Taitt and including other prominent policy-makers as well as public health leaders. The Task Force reviewed global development policies and their health implications, highlighting the effect of social conditions on health and arguing that health impact among vulnerable populations should be a central criterion in shaping policy choices for economic development. Among a range of other documents, the Task Force on Health in Development produced a WHO Position Paper for the 1995 World Summit for Social Development in Copenhagen. The paper interrogated the "trends towards privatization and market economies" that characterized the "globalization of the economic system." It argued that efforts to promote economic growth should be "accompanied by more equitable access to the benefits of development, as inequities have severe health consequences." And it stressed that health issues could be "most effectively addressed through intersectoral collaboration" to tackle factors such as poverty, unemployment, gender discrimination and social exclusion⁷⁵. Unfortunately, the Task Force's practical impact was not proportional to the moral strength of its arguments. The group proposed a valuable set of broad recommendations, but was not provided with mechanisms for implementation and follow-up. There was no systematic effort to recruit pilot or partner countries to apply the Task Force's advice in national policymaking and to measure outcomes. Within WHO itself, no structures had been foreseen to operationalize the Task Force's findings, and these lessons had little measurable influence on the Organization's country-level work and policy dialogue with Member States.

A major WHO effort in the mid-1990s was the attempt to reinterpret and reinvigorate the Health For All strategy under the banner of *Health For All in the 21st Century*⁷⁶. The revitalization of HFA included a renewed effort to promote intersectoral action as a key component of public health strategies. Thus, ten years after the landmark 1986 WHA technical consultations on intersectoral action for health, a new WHO

initiative on IAH was launched. The initiative produced a set of substantial scholarly papers and reviews of IAH experience at national and global levels and culminated in a major international conference in Halifax, Nova Scotia, in 1997. The existence of the IAH initiative attested both to continued recognition of the importance of the social and environmental determinants of health and the ongoing difficulties countries experienced in addressing them⁷⁷.

The arrival of Gro Harlem Brundtland as Director-General in 1998 brought significant changes in WHO's institutional agenda. Brundtland's priorities included a new initiative on malaria (Roll Back Malaria), a global campaign against tobacco and a rethinking of health systems. Brundtland is credited with having restored much of WHO's tarnished credibility in international development debates. However, this renewal came at a price, and the sacrifices affected areas of importance for the Organization's capacity to promote action on SDH. For example, the ambitions of *Health for All in the 21st Century* were sharply scaled back. In the area of health and development, Brundtland's signature was the Commission on Macroeconomics and Health (CMH), chaired by Jeffrey Sachs. The CMH's basic argument was not novel. But by putting numbers on the idea that ill-health among the poor costs the global economy vast sums of money, the CMH captured the attention of policy-makers. Quantifying in dollar terms the potential economic payoff of health improvements in low and middle income countries, the CMH helped secure fresh prominence for health as a development issue. Because it embraced the language of cost-effectiveness and looked at health in terms of returns on investment, the CMH may have been perceived as more realistic, pragmatic and in touch with the real world than earlier WHO initiatives such as the Task Force on Health in Development, which had discussed ethical values and invoked "the courage to care"⁷⁸.

2.8.3 SDH approaches at country level

Several countries made notable strides in the effort to address social dimensions of health through the 1990s and early 2000s.

The direct roots of contemporary efforts to identify and address socially-determined health inequalities reach back to the Canadian Lalonde Report⁷⁹ (1974) and the Black Report in the United Kingdom⁸⁰ (1980). The Black study had

little immediate policy impact in the UK, then governed by Prime Minister Margaret Thatcher's Conservative Party, whose leadership dismissed Black's recommendations as utopian. However, the document generated strong interest in portions of the scientific community. It inspired a number of comparable national enquiries into health inequalities in countries such as the Netherlands, Spain and Sweden. Public health specialists and political leaders in several countries began to explore policy options to address the troubling patterns the studies revealed – though action remained vulnerable to political power shifts (e.g., in Spain). Meanwhile the pervasive effects of social gradients on health were progressively clarified, in particular by data emerging from the Whitehall studies of comparative health outcomes among British civil servants, led by Sir Michael Marmot^{81,82}. In Canada during the early 90s, a remarkable interdisciplinary research effort sponsored by the Canadian Institute for Advanced Research (CIAR) brought together experts from public health and other natural and social science fields to explore together “the determinants of the health of populations”. The objective was not only to bolster scientific knowledge, but to identify effective policy options in answer to the question: “What can be done to improve a democratic nation's health status?” The group's key findings and recommendations, published in 1994 as *Why are some people healthy and others not?*, influenced debates in Canada and beyond⁸³.

The specific vocabulary of “social determinants of health” came into increasingly wide use beginning in the mid-1990s. Tarlov (1996) was one of the first to employ the term systematically. Tarlov identified four categories of health determinants: genetic and biological factors; medical care; individual health-related behaviours; and the “social characteristics within which living takes place”. Among these categories, he argued, “the social characteristics predominate”⁸⁶. A series of important publications generalized the use of this vocabulary⁸⁴. Researchers explored the questions of how social conditions and processes might translate into individual experiences of disease, as well as the contentious issue of whether social and economic inequality per se could be seen as comprising health status for all members of a society, such that at any given level of national income more egalitarian societies could be expected to exhibit better health than less egalitarian ones across the full range of socioeconomic positions^{85,86}. The growing sense that emerging evidence on SDH had

potentially far-reaching implications for public policy led to efforts to translate relevant scientific findings into language accessible to policy-makers and the general public⁸⁷.

The most rapid advances were made in a number of Western European countries, where in the late 1990s and early 2000s momentum gathered for systematic policy action to tackle health inequalities and address SDH⁸⁸. In some cases, notably Sweden, the result has been a dramatic reorientation of public health towards a social approach. In the UK, the arrival in power in 1997 of a Labour government responsive to health equity concerns sparked a wave of fresh research and policy innovation that put the country at the forefront of efforts to tackle SDH and reduce health inequalities. Outside of Europe, Australia, Canada and New Zealand have been leaders in research and policy action on the social dimensions of health, though tensions have surfaced between an SDH approach and strategies rooted in more market-based and individualized models of health and health care^{89,90}. Meanwhile, successful efforts to address SDH through public policy have not been limited to high-income countries. In the 1990s, a number of developing countries have also begun to implement promising policies and interventions to tackle the social roots of ill health. To provide a sense of the range of approaches being implemented; of obstacles and proposed solutions; and of the momentum that has begun to build around social determinants, we will next explore developments in a number of countries since the 1990s.

To survey and compare national SDH programmes and policies requires a typology that can enable them to be grouped coherently, so that their similarities and differences emerge. The following framework has been developed for that purpose. Building on Diderichsen, Evans and Whitehead (2001)⁹¹, Mackenbach et al (2002)⁹² and others, this framework classifies SDH policies according to their entry points: i.e., the stage of the social production of disease/well-being at which they seek to intervene. To visualize the relationships among these strategies, it is useful to adopt the image of a “social production chain” of linked mechanisms that lead from underlying social stratification to an inequitable distribution of health outcomes, and then back from poor health to people's socioeconomic position and opportunities.

The first entry point concerns programmes that

There are four key points along this chain where policies can intervene:

- ⑤ **By trying to decrease social stratification itself, i.e., to “reduce inequalities in power, prestige, income and wealth linked to different socioeconomic positions”⁹²;**
- ⑤ **By trying to decrease the specific exposure to health-damaging factors suffered by people in disadvantaged positions;**
- ⑤ **By seeking to lessen the vulnerability of disadvantaged people to the health-damaging conditions they face;**
- ⑤ **By intervening through healthcare to reduce the unequal consequences of ill-health and prevent further socioeconomic degradation among disadvantaged people who become ill.**

seek to alter the socioeconomic hierarchy itself via redistributive measures. The second and third reflect more modest intermediate strategies that aim to shield disadvantaged groups against the negative health consequences of their social position, for example by improving working conditions or reducing smoking rates among low-income groups. The fourth points to targeted medical care delivery strategies that seek to repair the damage social forces inflict on vulnerable people's health once that damage is already done, and to prevent the effects of illness from lowering people's socioeconomic status even further. A categorization of policies and interventions according to these four entry points should also be

crossed with a classification according to whether programmes aim for universal coverage or instead target specific groups within the population.

Based on the typology just sketched, several national programmes which took shape in the late 1990s are particularly illustrative. Among many cases that merit discussion, we have chosen four for the purposes of present analysis. They have been selected: (1) to illustrate the range of entry points identified above; (2) because lessons may be drawn not only from the actual content of the policies, but from the political processes through which they arose. The existence and accessibility of ample documentation on this political background

A comprehensive national public health strategy: Sweden

In the late 1990s, Sweden launched a new and innovative public health strategy based on a social determinants model. Tellingly, the strategy does not define its objectives in terms of morbidity or mortality figures. Rather, national health objectives are set by targeting the social and environmental determinants of disease. The overall goal of the strategy is “the creation of societal conditions that ensure good health, on equal terms, for the entire population”⁹³. Equity in health is thus a central and explicit aim of Sweden’s public health policy. The strategy aims to alter the pattern of social stratification that produces health inequities, while at the same time working at the intermediate level to address factors of specific exposures and vulnerability among disadvantaged groups.

The policy is based on 11 objectives reflecting the most important determinants of health:

- 1 Participation and influence in society
- 2 Economic and social security
- 3 Secure and favourable conditions during childhood and adolescence
- 4 Healthier working life
- 5 Healthy and safe environments and products
- 6 Health and medical care that more actively promotes good health
- 7 Effective protection against communicable diseases
- 8 Safe sexuality and good reproductive health
- 9 Increased physical activity
- 10 Good eating habits and safe food
- 11 Reduced use of tobacco and alcohol, a society free from illicit drugs and a reduction in the harmful effects of excessive gambling

The first six objectives relate to structural factors while the remaining five “are about lifestyle choices which an individual can influence, but where the social environment plays an important part. Responsibility for meeting these objectives is divided among various sectors and different levels in society”, including municipalities, county councils and voluntary organizations, in addition to national government⁹⁰. The program includes strategies to reduce housing segregation and social isolation, to increase participation in healthy leisure activities, to channel extra resources to needy schools, and to reduce unemployment and eliminate employment discrimination against immigrants. In essence, this approach seeks to strengthen conditions that improve health in society that will in turn improve the health of individuals, particularly among the most vulnerable groups.

The strategy builds both on a Swedish cultural tradition of solidarity and on a governmental model of evidence-based decision-making⁹⁴. Sweden has a longstanding interest in the vital statistics of its population. Since the 18th century the government has kept records of births, deaths and causes of mortality. This has afforded Sweden a strong statistical evidence base with which to pinpoint trends and causal patterns in health.

The new public health policy came to fruition through a consultative political process in which representatives of all Sweden’s major political parties and of civil society were engaged. Demand for action on the social causes of health outcomes was expressed by researchers, politicians, county councils, municipalities and health care providers, who called for guidelines and national objectives. Support also came from trade unions and non-governmental organizations. The availability of reliable data to show the existence and patterns of health disparities was a major factor in galvanizing pressure for action.

A member of the secretariat supporting development of the policy reported that, in the policy design process, surveys were sent to different government sectors to explore how their sectoral activities influenced public health; taking a social determinants perspective - as opposed to a disease perspective - it became relatively easy for non-health sectors to think through the health consequences of their activities. In this way other sectors were closely involved in the policy design process from early on. Through the preparation, circulation and iteration of “green papers”, they were able to give their feedback to the commission. Participation from civil society groups was also encouraged. Civil society organizations received green papers for comment, and many provided substantive input⁹⁴.

Coordinating national and local policy to tackle health inequalities: United Kingdom

The recommendations of the 1980 Black Report had little impact in Britain during the years of Conservative government (1979-1997). Over this period the social health divide documented by Black widened considerably. By the late 1990s, English men born to professional parents could expect to live on average almost 10 years longer than those whose fathers have unskilled jobs. Small steps to tackle “variations in health” during the last years of Conservative government did little to alter the trend. The years of Conservative rule saw a substantial widening of income inequality in the UK and an explosion of the number of families living on low incomes. By 1998-99, 14.3 million people (about one-quarter of the population) and 4.4 million children (about one in three) were living in households receiving less than half the average national income⁹⁵.

Assuming power in 1997, Labour Prime Minister Tony Blair made action on health inequalities a major national policy focus. Within a month of taking office, Blair publicly acknowledged the link between poverty and health (a connection leaders of the previous government had been unwilling to draw). The Labour government appointed Sir Donald Acheson to chair an Independent Inquiry into Inequalities in Health, charged with “identify[ing] priority areas for future policy development ... to reduce health inequalities”⁹⁶. Released in 1998, the Acheson Report furnished a comprehensive synthesis of scientific evidence on a range of topics linking social conditions and health and presented 39 recommendations. Of these, the Inquiry Committee highlighted three as especially crucial:

- ❶ All policies likely to have an impact on health should be evaluated in terms of their impact on health inequalities
- ❷ A high priority should be given to the health of families with children
- ❸ Further steps should be taken to reduce income inequalities and improve the living standards of poor households.

The Independent Inquiry thus strongly emphasized the importance of policy action to reduce inequalities of wealth and resources within society, in order to address health inequalities at the root (entry point one, above). The government moved to align its policies with key recommendations of the Acheson report. *Reducing health inequalities: an agenda for action*, published in 1999, summarized the government’s efforts across a range of areas, including:

- ✔ Raising living standards and tackling low income through increasing social benefit levels and introducing a minimum wage
- ✔ Focusing on education and early child development, for example through the creation of “Sure Start” preschool services in disadvantaged areas
- ✔ Strengthening employment by creating a range of welfare to work schemes for priority groups
- ✔ Building healthy communities through regeneration initiatives in disadvantaged areas, including the creation of Health Action Zones^{95,97}

In 2001, the Secretary of State for Health announced two major national targets for the reduction of health inequalities by 2010, one defined in terms of a target population defined by occupation/social class, the other defined geographically in terms of disadvantaged areas. The goals are: (1) to reduce by at least 10 percent the gap in mortality between manual groups and the population as a whole; and (2) to reduce by at least 10 percent the gap between the fifth of areas with the lowest life expectancy at birth and the population as a whole⁹⁸. It was recognized that to meet these targets will require action across all levels and departments of government, bridging traditional boundaries of responsibility. Accordingly, a Treasury-led Cross Cutting Review on Health Inequalities took place between mid-2001 and mid-2002 to examine how the work of government departments and programmes could be coordinated towards achieving the targets and how government spending could most effectively reduce health inequalities⁹⁹.

The government’s overall strategy to narrow health gaps through action on social determinants is distinctive for its simultaneous emphasis on broad redistributive efforts coordinated at national level and on locally managed area-based initiatives. Among the major national redistributive programmes, one of the most ambitious was the introduction of the UK’s first-ever national minimum wage in April 1999. Over 1.5 million low-wage workers were entitled to higher pay as a result of this measure. This and other national measures over the New Labour government’s first four budget cycles had a positive impact on income inequality nationally. Families at the bottom end of the income distribution saw their incomes rise between 1997 and 2000 (by roughly 9 percent for those in the lowest decile), while those in the highest income deciles experienced a modest fall in incomes⁹⁵.

At the same time, local area-based initiatives have also been promoted as a key mechanism to strengthen health in disadvantaged communities by improving living conditions and tackling social exclusion. Among the most widely discussed of the area-based initiatives are the Health Action Zones (HAZ) established in 1997 in 26 disadvantaged neighbourhoods across the country. HAZs involve partnerships between local statutory agencies, health authorities and voluntary and community groups who work together to develop innovative ways to reduce health inequalities. Originally designed as 7-year pilot projects, HAZs were intended “to explore mechanisms for breaking through current organizational boundaries to tackle inequalities and to deliver better services”¹⁰⁰. Activities undertaken covered a broad range of social determinants. They included expanding training and job opportunities for local people; promoting educational attainment among the disadvantaged; building social cohesion through a variety of community support strategies; and improving access to health care. Initial progress on HAZ was uneven, and some local actors resented a belated decision by national officials to require all HAZs to demonstrate their contributions towards national priorities in cardiovascular disease, cancer and mental illness – a move that seemed to compromise local autonomy. Despite these difficulties, however, HAZ and other local initiatives have contributed promising innovations in addressing some key SDH. In some cases, health awareness and understanding of the impact of SDH have been raised at community level, and local stakeholders have been energetically engaged¹⁰⁰.

SDH entry points and the future of the welfare state: Canada

Canada has long been regarded as a leader in international public health, particularly in addressing the broad determinants of health and strengthening community involvement in public health processes¹⁰¹. The 1974 Lalonde report was among the first studies to propose a comprehensive framework for understanding health determinants - including lifestyles, social and physical environment - and to acknowledge the limited role of health care in improving health. Other noteworthy Canadian public health initiatives include the 1980s healthy communities movement and the 1986 Ottawa Charter for Health Promotion. The country's research tradition in medicine, public health and the social sciences has enabled Canada to contribute significantly to the global scientific knowledge base on SDH, and has also fuelled vigorous domestic policy debates.

Canada's federalist political system assigns primary responsibility for health and social policy to the provinces and territories, rather than centralizing decision-making at national level. The 1990s saw important progress in building policy environments receptive to SDH approaches across federal, provincial and territorial governments. In 1994 the country's Ministers of Health adopted intersectoral action for health as one of the key directions for improving the health of Canadians¹⁰². A 1998 Health Canada position paper identified an array of health determinants as potential targets for policy action, including: "income and social status, social support networks, education, employment and working conditions, ... healthy child development, health services, gender and culture"¹⁰³. In 1999, all levels of government endorsed a population health approach, which focuses on the upstream causes of health outcomes. The population health model aims to address the interrelated conditions and factors that influence people's health over the life course. It identifies systematic variations in the social distribution of such factors and applies the resulting knowledge to develop and implement policies and actions. Reducing inequities between population groups is an overarching goal, and intersectoral action for health a prominent strategy¹⁰⁴.

Canada's federal structure has both an enabling and a complicating influence on public health, and in particular on efforts to address SDH. Many successful examples of intersectoral action for health at local level have emerged, and some provinces have made impressive progress with policies on selected social determinants. However, overall national coordination is difficult, and some critics have charged that broad commitments in principle to an upstream focus in public health policy have been slow to translate into concrete action^{101,105}. A 1997 article by Sutcliffe and colleagues reported that "many provinces had no evidence of mandated programs ... that addressed the broader determinants of health or that used multiple strategies"¹⁰¹. In the early 2000s, the medical care system continued to absorb the majority of health sector resources, with less than 3% of health spending allocated towards health promotion and prevention^{105,106}.

National debates on health and health care policy intensified in the late 1990s, entwined with wider discussions about the future of the welfare state and the growing influence of neoliberalism on Canada's economy and public life. The 90s were perceived as an era of broad prosperity, yet economic gaps between the country's haves and have-nots had widened substantially during the decade¹⁰⁷. Teeple (2000) described the political and economic conditions that had enabled the creation of the Canadian welfare state after World War II, including strong national identity and a perceived need to mitigate class conflict¹⁰⁸. He showed how those conditions had changed since the 1970s, with economic globalization and a shift towards neoliberal models affecting policy environments. Drawing on such analyses, some Canadian public health experts critiqued the trend towards liberalization and privatization, which they saw coupled with a growing public health focus on individual risk factors at the expense of underlying social and economic inequities. Discussion of public health and SDH policy in Canada continues to contrast advocates of strong redistributive measures aimed to reduce social stratification (entry point 1) with defenders of a less ambitious approach based on reducing exposures and risks among disadvantaged groups (entry points 2-3)¹⁰⁹.

A multi-pronged programme for disadvantaged families: Mexico's Oportunidades

Mexico's successful Oportunidades programme shows that innovative policy action on SDH can be achieved in developing countries. Oportunidades (until 2002 PROGRESA) is an anti-poverty program in which conditional cash transfers are used to induce poor parents in rural areas to send their children to school, improve the use of preventative and other medical services and adopt better nutrition. First launched nationally in 1997, the program has produced such positive results in improving health and education outcomes that the government has expanded it to poor families in urban settings, as well. Oportunidades is underpinned by the idea that there is a synergistic, mutually reinforcing effect of improvements in education, health and nutrition; it has succeeded in beginning to transcend the "silo" mentality of social sector ministries¹¹⁰. The programme is by definition targeted rather than universal in coverage. It seeks to shield poor families against certain forms of differential exposure and vulnerability, while also facilitating improved access to healthcare services (our entry points 2-4).

The central goal of Oportunidades is to increase the capacities of the extremely poor in Mexico, who were identified on the basis of a multilevel targeting strategy¹¹¹. The program's design is unconventional in that it provides monetary incentives – equivalent to a 25 percent increase in family income – to families to increase their use of health services and schooling, with the ultimate goal of inducing parents to make decisions that will provide their children with better health and education. The cash transfers are given to the mother of the family, an intentional strategy which is designed to target funds within the household to improving the children's education and nutrition¹¹². Importantly, plans for rigorous, independent monitoring and evaluation were built into Progresá from its inception, strengthening the programme's scientific and political credibility by documenting quantifiable outcomes in each of the programme's three target areas.

In health, Progresá (and subsequently Oportunidades) disbursed cash transfers only if all family members accepted preventative health services delivered by a branch of the Mexican Social Security Institute¹¹³. The health package is aimed at the most common health problems as well as the most significant opportunities for prevention such as sanitation, family planning, care before and after childbirth, prevention and treatment of respiratory infections, accident prevention and first aid, among others¹¹⁴. At the same time, the program seeks to improve the quality of services available through public providers, particularly through ensuring a steady supply of medicines, more doctors and nurses and higher wages for healthcare providers¹¹⁰. Results from a 2001 World Bank sponsored study showed increased utilization of public health clinics for preventative care, fewer inpatient hospitalizations and a significant improvement in the health of both children and adults who took part in the programme; Progresá children experienced a 23 percent reduction in illness, a 1 - 4 percent greater increase in height and an 18 percent reduction in anemia, relative to children not in the programme¹¹². Adults reported a reduction in the number of days of difficulty with daily activities due to illness and in the number of days in bed due to illness, as well as a significant increase in the number of kilometres they were able to walk without being tired.

In education, grants are provided for each child under age 18 who are enrolled in school during the period when the risk of dropout is the greatest (the third grade of primary school and the third level of secondary school). Since children are often relied upon to supplement the family's income in times of economic hardship, the size of the grant was calibrated to partially compensate for the lost wages, which increases as the child progresses through school. Moreover, a slightly larger grant was given for girl children, out of recognition of the fact that they are more likely to drop out of school than boys. As a result of the program, there were increases in secondary school enrolment which ranged from 11 to 14 points of girls and 5 to 8 percentage points for boys. Transitions to secondary school increased by nearly 20 percent and child labour declined¹¹⁵.

To strengthen nutrition, cash transfers are disbursed only if children aged 5 and under and breastfeeding mothers attend nutrition monitoring clinics where growth was measured, and if pregnant women visited clinics for prenatal care, nutritional supplements and health education. In addition, a fixed transfer of \$11 per month is provided for improved food consumption. Nutritional supplements at a level of 20 percent of caloric intake and 100 percent of the micronutrient requirements of children and lactating women are also provided. A 2000 evaluation found that children under 5 who were required to seek well-child care and who received nutritional support had a 12 percent lower incidence of illness than children who were not in the program¹¹⁶. Nutritional status was better for programme children, resulting in a reduced probability of stunting among children 12 to 36 months of age¹¹⁷. In addition, beneficiaries reported both higher caloric consumption and a more diverse diet, including more fruits, vegetables and meat. Iron deficiency also decreased by 18 percent¹¹⁸.

The Mexican government was committed to scaling up the program from its launch in 1997. By 2000, it covered approximately 2.6 million families, about one-third of Mexico's rural families, and operated in 50,000 rural villages¹¹⁹. The Inter-American Development Bank in 2002 approved a grant of US\$1 billion - its largest ever loan to Mexico - for the consolidation and expansion of Progresá to urban areas, and to ensure medium- and long-term sustainability. The success of the Progresá/Oportunidades program has led to an expansion of this kind of multisectoral approach to other parts of Latin America including Argentina, Brazil, Columbia, Honduras and Nicaragua.

Rigorous external evaluation of the project has been a key part of maintaining political legitimacy. As a result, the program has enjoyed strong political support at the presidential level and within the federal Secretariats of Education, Health and Social Development. During the political transition of 2000, the robust evaluation results and ongoing political commitment to fight poverty made it possible for the programme not only to survive, but to expand¹²⁰.

was an influencing factor in the choice of examples. The preceding examples describe only a few of the national-level policy responses to SDH that began to emerge in the 1990s and have continued and expanded in many settings. These examples highlight both the momentum building around SDH and some of the major scientific and political issues that continue to spark debate.

2.9 The 2000s: growing momentum and new opportunities

In the 2000s, policy action on SDH has continued to advance in several countries^{88,90}. Meanwhile, the broader global health and development context has evolved in ways that provide strategic openings to further expand these achievements.

Today, the global development agenda is increasingly shaped by the Millennium Development Goals (MDGs), adopted by 189 countries following the United Nations Millennium Summit in September 2000. The 8 MDGs are linked to quantitative targets and indicators in poverty and hunger reduction; education; women's empowerment; child health; maternal health; control of epidemic diseases; environmental protection; and the development of a fair global trading system. Crucially, the MDGs have refocused attention on the need for coordinated multisectoral action. The MDG framework overcomes the idea that developing countries' urgent social and development problems can be addressed in isolation from each other, through "silo"-style policy approaches in specific sectors. Without progress in fighting poverty, strengthening food security, improving access to education, supporting women's empowerment and improving living conditions in slums, for example, the health-specific MDGs will not be attained in many low- and middle-income countries. At the same time, without progress in health, countries will fail to reach their MDG targets in other areas.

Three of the eight MDGs are directly focused on health, and several of the other goals have important health components, confirming

that, overall, health in the 2000s stands higher on the international development agenda than ever before^{1,121}. This new prominence has been nourished both through high-level exercises such as WHO's Commission on Macroeconomics and Health and by the ongoing efforts of communities and civil society groups mobilized to press their demands for health as a human right. The increasing importance of health as a development issue has intertwined with a growing awareness and concern about health inequalities between and within countries. The concern with health inequalities creates additional opportunities to leverage action on SDH – since social factors are at the root of most health disparities.

Meanwhile, the wide support garnered by the MDGs signals the emergence of a new, relatively more consensual climate in international health and development, moving beyond some of the polarizations of the 1990s and creating a foundation for more collaborative partnership work among diverse actors. The 1990s were characterized by ideologically charged confrontations on globalization, often cast as either "all good" or "all bad". This climate of binary opposition has given way to more nuanced analyses in many circles. Recognizing the complexity and ambiguity of unfolding global political-economic processes, many actors have committed to a more pragmatic cooperative stance.

A shared interest has emerged in maximizing the real benefits of global processes while at the same time acknowledging the harm they can cause, in particular to vulnerable groups, and instituting policies to limit these negative effects and achieve a more equitable distribution of costs and benefits^{122,123}.

Armed conflict, environmental degradation and concerns about global security continue to pose major threats and to provoke polarization. However, overall, a clearer sense of global interdependence has emerged, and stakeholders in different countries and sectors are increasingly conscious that they must work together. The awareness of interdependence underpins the MDGs as an unprecedented global compact between developed and developing nations⁷. Similar ideas informed the March 2002 International Conference on Financing for Development in Monterrey, Mexico. While progress remains uneven towards the long-standing development assistance target of 0.7 percent of donor GNP, the cumulative force of the Millennium and Monterrey pledges marks a shift of mindset in development cooperation. Under the MDGs and Monterrey commitments, “countries have agreed to hold each other to account, and citizens of both high-income and low-income countries are empowered to hold their own governments to clear standards”⁸.

The 2000s have also seen an evolution in WHO’s role in promoting action on health equity and the social dimensions of health. In 2003 Lee Jong-wook was elected WHO Director-General on a

platform of renewed connection to Health for All values, mediated through Lee’s personal style as a pragmatic consensus-builder. In a December 2003 article in the *Lancet*, Lee wrote:

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 context¹²¹.

In his address to the 57th World Health Assembly in May 2004, Lee announced WHO’s intention to create a global commission on health determinants to advance a pro-equity agenda and strengthen the Organization’s support to Member States in implementing comprehensive approaches to health problems, including their social and environmental roots. Lee stated that the commission would be oriented towards practical action. “The aim is to bring together the knowledge of experts, especially those with practical experience of tackling these problems. This can provide guidance for all our programmes”¹²⁴.

3 Taking it to the next level: the Commission on Social Determinants of Health

3.1 Aims of the CSDH

The CSDH has been constituted at a time when momentum for action on SDH is rising. A convergence of factors related to the scientific evidence base, the mobilization of concerned constituencies and the broader politics of development has created conditions in which unprecedented advances in health policy to address SDH are within reach. But many countries and communities remain excluded – particularly in parts of the world where health needs and the negative impacts of SDH are greatest. A major push is needed now to capture the existing momentum on SDH and take it to the next level: brokering a wider understanding and acceptance of SDH strategies among decision-makers and stakeholders, particularly in developing countries; translating scientific knowledge into pragmatic policy agendas adapted to countries' levels of economic development; identifying successful interventions and showing how they can be scaled up; and ensuring that social determinants are lastingly anchored in health policy approaches at WHO and among other global actors. These are the tasks the CSDH will take on.

During its three-year span of activity, the Commission aims for changes whereby the societal relationships and factors that influence health and health systems will be visible, understood and recognized as important. Based on this the opportunities for policy and action, and the costs of not acting, will be widely known and debated. A growing number of institutions working in health at local, national and global level will be using this knowledge and implementing relevant public policy affecting health. Leadership, public interest and capable institutions within and beyond the health sector will sustain this transformation. The

social determinants of health will be incorporated into the planning, policy and technical work of WHO.

The aims of the CSDH are ambitious. To achieve them, it will have to build on the work of predecessors, understand their limitations and obstacles, and go farther. To do this will involve strategic decisions guided by an understanding of history.

3.2 Key issues for the CSDH

The preceding historical overview brings into focus both some of the challenges the CSDH can expect to face, and the reasons why this effort is so vital now. It offers lessons for the CSDH and raises questions Commissioners may debate as they define their objectives and strategies more precisely. In the following pages, we focus on four issues where the historical survey has shown to be particularly crucial. In each of these four areas, we identify a specific question or questions on which the Commission will need to achieve clarity.

3.2.1 The scope of change: defining entry points

Efforts to promote change in health policy can be more or less ambitious in scope. This issue is illustrated historically by the contrast between comprehensive and selective primary health care, i.e., between the Health for All agenda as protagonized by Mahler at Alma-Ata and the Child Survival Revolution led by Grant and UNICEF in the 1980s. The CSDH will face its own version of the challenge and the choice embodied in these two figures and their respective strategies. On the one hand, the Commission could understand

itself as leading a “Copernican revolution” in thinking and action on health policy, with far-reaching implications for social structures and for how governments do business in exercising their responsibility for the health of populations. On the other hand, the CSDH could set its sights more modestly and aim simply to develop and promote a “toolkit” of interventions that states can implement swiftly, without significant changes to their existing governance and budget structures or their relationships with international financial institutions and donors (the SDH equivalent of the GOBI strategy). And of course the choice need not be cast as a binary alternative. Various compromise positions might be sought that could combine some of the strengths of both approaches. Yet the fact remains that the CSDH will inevitably have to “come down somewhere” on what might be termed the Mahler-Grant problem. This positioning should be the result of a conscious, reasoned and collective choice, rather than simply emerge haphazardly from the Commission’s day-by-day interactions with partners and the media.

At the communications level, this decision is about a choice of vocabulary for the Commission (e.g., “social justice” vs. “efficiency” or “reducing disparities”). At the level of country operations and policy, it is about entry points. Decisions about language are not “mere” linguistic subtleties, but have implications for the way the CSDH will work with countries and the types of policies it will seek to promote. As shown in the country examples above, policies and interventions to address SDH can engage social structures at a variety of levels. The most ambitious policies may seek dramatically to reduce gradients of wealth and power among different groups in society through redistributive processes. At the other end of the spectrum, healthcare interventions targeted at disadvantaged groups seek to repair or palliate the damage inflicted by social inequality, once such inequality has already translated itself into physical illness affecting the bodies of disadvantaged individuals. Along this spectrum, it will be crucial for the CSDH to identify the level(s) at which it will seek to promote change. A typology or mapping of entry points for policy action on SDH and health inequities was sketched earlier.

In essence, this framework asks at what point(s) along the chain of social production of health/illness it is desirable (and feasible) to intervene in a given context: through broad redistributive policies that aim to alter fundamental social

inequalities; through less ambitious, intermediate policies that seek to shield members of socially disadvantaged groups against the worst health consequences of their increased exposure to health threats (examples would include anti-smoking programmes targeted at low-income groups and occupational safety regulations that reduce health risks connected with specific forms of low-prestige work); or by providing fairer medical care at the end of the “social production chain”.

Linked to the question of entry points is the issue of universal versus targeted programmes. Graham and Kelly recall that evidence on the links between people’s socioeconomic circumstance and their health has thus far generated two kinds of policy responses¹²⁵. The first focuses on those in the poorest circumstances and the poorest health: on the most socially excluded, those with most risk factors and those most difficult to reach. This focus has been important in linking health inequalities to the social exclusion agenda, and in focusing policies at local and community level. In policy and intervention terms, this leads to approaches that attempt to lift the worst off out of the extreme situation in which they find themselves. In effect, such interventions help only a relatively small part of the population. The second approach recognizes that, while those in the poorest circumstances are in the poorest health, this is part of a broader social gradient in health. This means that it is not only the poorest groups and communities who have poorer health than those in the most advantaged circumstances. In addition, there are large numbers of people who, while they could not be described as socially excluded, are relatively disadvantaged in health terms. Preventive and other interventions could produce major improvements in their health and proportionate savings for the healthcare system. Because universal programmes may be seen as too costly, there is a risk that strategies will focus primarily on targeted interventions addressing intermediary determinants, which simply manage the consequences of poverty, while the processes that cause it remain unchanged¹²⁶. Indeed, some critics argue that an unintended effect of targeted interventions may be to legitimize poverty, making it both more tolerable for individuals and less costly for society¹²⁷. Commissioners will want to reflect carefully about the level(s) at which they want to promote change; the desirability/feasibility of selecting various policy entry points; the forces and capacities for action that must be aligned at the various levels; and the appropriate political strategies for obtaining results.

Determinations about policy entry points and the content of recommended policies will vary with the specificities of national contexts. Successful health policy to address SDH cannot adopt a “one-size-fits-all” character. Different countries and jurisdictions find themselves at very different stages of readiness for action on SDH and of openness to more fundamental redistributive approaches⁸⁸. The particularities of national and local contexts will show which social determinants need to be addressed most urgently to improve population health, and which policy tools are most appropriate. National and local specificities, in particular economic and political power relations, will define the opportunities and constraints for action and indicate which constituencies may align themselves with an SDH agenda, and which may offer resistance. Thus, the key question becomes not only “What entry point(s) will be chosen?” but also and more fundamentally, “How will you decide?” That is, what criteria will be utilized to make decisions about the level of policies/interventions to be recommended in particular cases?

Presumably, in addition to a framework of entry points for SDH interventions and policies, the CSDH will need to develop a typology of countries and/or subnational jurisdictions with respect to their capacities for action on SDH. Elaborating this typology will be an important task for the Commission’s scientific team and lies well beyond

the scope of the present paper. Some key points can be noted, however. National income will be an important differentiator, and wealthy countries will presumably in most cases have considerably greater facility for implementing comprehensive SDH policies than will poor countries. However, as *Good health at low cost* made clear in the 1980s, and as many subsequent studies have confirmed, income is not the only relevant factor. Countries with roughly equivalent levels of national income exhibit very different levels of performance in areas of social achievement with relevance for health, such as access to adequate food for all members of the population; housing quality; water and sanitation; and education. The CSDH typology will thus have to group countries not only by income level, but with reference to the other, in some cases less easily quantifiable factors that will shape opportunities for action. In exploring contextual influences on health systems, Roemer, Kleczkowski and Van Der Werff¹²⁸ have proposed a typology of countries that points toward what may be relevant variables. They classify countries based on three criteria:

- ✔ The extent to which health is a priority in the governmental /societal agenda, reflected in the level of national resources allocated to health;
- ✔ The degree to which responsibility for financing and organizing the provision of health services to individuals is assumed as (1) a collective social responsibility or (2) primarily the responsibility of the individuals concerned;
- ✔ The extent to which society (through political authorities) assumes responsibility for an equitable distribution of health resources.

As the GHLC analyses acknowledged, but as technical planners sometimes forget, a country’s political, economic and social history is deeply relevant to understanding what policies will be appropriate and effective there¹²⁹. This principle applies a fortiori to efforts to mobilize constituencies, engage policymakers and implement interventions on SDH.

Down the line, the issue of national specificities and appropriate modes of engagement will raise a range of important strategic questions for the Commission. These include how the CSDH will co-operate with countries whose political structure is federal (see Canada example above), and what sorts of policy recommendations and support the

DEFINING THE SCOPE OF CHANGE: MAIN STRATEGIC QUESTIONS

- **How will the CSDH position itself on the “Mahler-Grant problem”: i.e., choosing (or compromising) between: (1) a far-reaching structural critique based on a social justice vision and (2) promoting a number of tightly focused interventions that may produce short-term results, but risk leaving the deeper causes of avoidable suffering and health inequities untouched?**
- **What evaluation criteria will the CSDH put in place to identify appropriate policy entry points for different countries/jurisdictions?**

CSDH may seek to provide to constituencies in countries whose economic and political situations (including conflict and/or highly authoritarian, unresponsive governance) make major national health policy action on SDH extremely unlikely in the near and medium term. Will such countries be (tacitly) “written off” by the CSDH as cases in which Commission resources and energy cannot sensibly be invested, or will some effort be made to develop recommendations and policy dialogue in these settings that could begin to lay foundations for long-term change?

3.2.2 Anticipating potential resistance to CSDH messages – and preparing strategically

On the question of why policy action on SDH has lagged in most settings, the existing literature presents two main explanatory strands. The first sees the blockage as a problem of knowledge, the second as a question of power¹³⁰. According to the first account, action to address SDH has been weak because the evidence base on which to build such action is inadequate, or existing evidence has not been effectively communicated to those in a position to effect change. The second account emphasizes the political-economic dimension of power and profit, and suggests that the most important barriers to action on SDH lie in this area. It sees policy failure on SDH not primarily as a symptom of ignorance, but as the logical consequence of existing power relations. Notably the fact that certain influential constituencies derive benefit from a status quo in which SDH are not addressed, and believe their interests would be compromised if policies were enacted to tackle social determinants aggressively.

The key objectives of the CSDH clearly include filling gaps in the scientific evidence base relative to social determinants and effective policies and interventions to address them. The very existence of the Commission reflects the conviction that effective communication of SDH messages to policy-makers, health and development actors and the broader public can help catalyse action that will significantly improve vulnerable people’s chances for health. However, the CSDH must also take seriously the second explanatory strand just evoked, centred on political-economic power relations. Our historical survey has suggested that it is not primarily the lack of knowledge that has thus far hampered action on SDH. Over the past quarter century, the evidence available has been sufficient for most countries to acknowledge in

principle (via numerous declarations and official statements) the urgent need for such action. However, between that acknowledgement and the actual implementation of meaningful policies, political barriers have often emerged.

It is particularly important that the CSDH focus on these issues at the very outset of its activities. Designing and carrying through a process to collect scientific evidence will in a sense be obvious and “natural” to many Commissioners and their support staff; addressing the political barriers may be less so. Yet if the political strategy is not well developed, the evidence collection, however scientifically sound, may fail to generate the concrete change the Commission seeks.

Scholars have begun to analyse the political/structural aspect of resistance to SDH approaches^{89,130}, but much work remains to be done. This paper cannot map the relevant power relationships in exhaustive detail, since the particularities of national and local contexts will once again be crucial, and relevant constituencies will vary across the range of thematic areas the Commission will address (e.g., food security, housing, social exclusion, etc.). This detailed political mapping will be a primary responsibility for the Commission’s Knowledge Networks and for the co-ordinating groups in each partner country. What the present paper can do is identify several broad constituencies likely to feel their interests are threatened by SDH policy approaches. By focusing clearly on these constituencies and understanding their respective stakes in processes related to SDH, the Commission can develop strategies to draw them into the CSDH process through dialogue or, failing that, to minimize the damage caused by their resistance.

The medical establishment

SDH agendas, including efforts to advance health promotion and intersectoral action, have in the past encountered active or passive resistance on the part of many medical professionals and institutions^{14,16,89}. It is reasonable to suppose that this pattern will continue under the CSDH. A significant challenge for SDH and health equity agendas will be bringing the medical establishment on board as a constructive partner.

Health care providers, especially physicians, are generally part of the social elite, and share its values and class interests. Like other members of privileged social categories, they will resent and often resist government policies that

redistribute resources from the more advantaged to the less well-off in society. Furthermore, and more importantly, physicians have a strong group interest in maintaining their monopoly over authoritative discourse and practice around health. Medical professionals are reluctant to see control of health issues slip away from them to other sectors and professional constituencies, or to cede to communities the power to set health agendas. The atrophy of intersectoral action and the widespread discrediting of community participation under Health for All partly reflected this persistent dynamic, although other causal factors were also relevant.

The reasons for this pattern have to do in part with doctors' desire to maintain their social prestige, but the more fundamental issue is economic. Individual physicians and the medical establishment as a whole make money by providing curative interventions. They will not make money from the introduction of a school feeding programme or improvements to the housing stock in a slum neighbourhood. McGinnis et al. (2002) have underscored the inherent structural asymmetry between public health and the provision of curative medical care, when it comes to political clout and the competition for resources. This issue must be of concern to the Commission as it develops its approach to policy dialogue.

In many settings the structural configuration of health governance institutions has combined with "interest group dynamics" to result in a "vacuum of political accountability for maintaining population health". In contrast, "a well-defined set of actors – physicians and other health care providers – has responsibility for medical care"⁵.

In addition to their ethical commitment to deliver medical services to those who need them, "providers have a strong financial incentive to provide medical care, as well as an interest-group incentives to lobby for increasingly more

medical care resources"⁵. To the extent that SDH programmes are seen as competing for these scarce resources that might otherwise be invested in medical care, health care providers and other constituencies that derive profit from patient care and related services may resist them.

Within national governments

SDH interventions represent major opportunities to improve the health status of populations, particularly vulnerable groups, at relatively low cost. National governments should be eager to pursue these policies. However, the desire and/or the technical capacity of governments to implement such approaches can by no means be taken for granted.

The Ministry of Health may be wary of social determinants approaches, because these may be seen both as channelling health funds away from the MoH towards other government departments, and as loosening the MoH's scientific and political authority over health. Making health "everybody's business" *should* register as a highly constructive development, but it *could* also be seen as a diminishment of the power and prerogatives of the MoH and health sector specialists. At the same time, earlier experiences in IAH suggest that non-health ministries and government officials may (at least initially) also be reluctant to commit time, energy and resources to work oriented towards health goals⁴².

In general, many elected officials must of course make their own tacit cost-benefit calculations in terms of election cycles and the need to quickly deliver tangible benefits to electors. They operate on a compressed time-frame and seek opportunities for "quick wins", with a preference moreover for policy options where the causal link between intervention and outcome is obvious. In contrast, some SDH programmes might require years or decades to really begin generating major measurable effects. Such efforts will do little to advance decision-makers' immediate electoral interests. Furthermore, the lines of causality in intersectoral action are notoriously complex, making it difficult in many instances to prove that a particular programme was the source of a given health improvement. Added to this is the consideration that the prime beneficiaries of many SDH interventions would be poor and marginalized constituencies who are often less likely to participate in the political process and thus to "pay off" in terms of votes for politicians.

As McGinnis et al. argue:

“It takes more than just evidence that social change would improve health to convince the general public [or a fortiori policymakers] that such redistributive investments should be undertaken. These choices are very much about ideology and social values⁵”.

Some government leaders will be opposed to many aspects of an SDH programme on ideological grounds, because they will see SDH interventions as largely constituting unnecessary government interference in processes better left to market forces and individual choice/responsibility. The resistance to the introduction of new, government-led redistributive policies will be encountered among leaders of some wealthy countries eager to secure global dominance for the neoliberal “free market” model; it can also be expected among officials in some developing countries who are strongly lobbied and influenced either by private sector interests or by major global institutions closely aligned with the neoliberal agenda. Moreover, even in countries interested in adopting redistributive mechanisms to address SDH, governments may be unable to implement such programmes: because of lack of resources; as the result of social sector spending ceilings and other constraints imposed by IFIs and donors; or because of the shortfalls they face in terms of human and other resources for planning, implementing and managing complicated social programmes. At the same time, many developing country policymakers and programme implementers exhibit an (understandable) level of “initiative fatigue”, scepticism and resistance to priorities seen as imposed from outside. Such resistance is an inherent obstacle to the introduction of *any* major new programme initiative in some developing countries. Thus it will be crucial for the CSDH to co-ordinate its policy recommendations with the existing structures and policy frameworks through which countries operate, and which govern relationships between developing countries and donors (e.g., PRSPs). The CSDH must not be seen as piling on yet another set of “global

priorities” and recommended actions with no clear relationship to the structures and processes currently in use.

The corporate sector

Resistance to certain CSDH policy recommendations – as to previous attempts to catalyse action on health risk factors such as smoking and diet – is likely to come from some corporate and commercial interests. Homedes and Ugalde (2005) have shown that neoliberal health sector reforms in Latin America have primarily benefited large corporations. They argue that under these reforms: “Excluded health policies are those that have a negative impact on corporate profits such as safety programs in factories and agriculture, accident reduction in vehicle transportation, tobacco reduction, the promotion of generic drugs, and the promotion of essential drug lists”⁵⁴. If the corporate sector and its allies have opposed such components within health sector programming, it is reasonable to assume they will resist similar strategies proposed under the banner of SDH.

The most obvious tensions for an SDH agenda may arise with those corporations that profit directly from the marketing of potentially health-damaging products and lifestyles: e.g., manufacturers of tobacco products; sugar; fast food and junk foods; alcohol; automobiles; and weapons. As McGinnis et al. note for the US context: “The behavioural issues that together account for so many deaths – tobacco, alcohol, dietary excess and sedentary lifestyles – are all products in part of strong commercial forces. Tobacco and alcohol represent US industries with annual sales of well over \$100 billion. The food industry spends billions just on advertising and promotion”⁵⁵.

In this sense, the sustained effort to confront the tobacco industry and to establish the Framework Convention on Tobacco Control may provide lessons for the work of the CSDH¹³¹. Yet the situation of an SDH agenda with respect to corporate interests is more complex than in the case of tobacco. Rather than a single industry (and one moreover with a largely negative public profile), SDH interventions may be seen as potentially threatening the interests of national and transnational companies in a variety of different sectors, including some of the world’s most powerful and beloved consumer product brands. The recommendations that will emerge from the Commission’s Knowledge Networks

on employment/working conditions and globalization/trade are particularly sensitive in this regard. Numerous transnational corporations are strongly inclined to fight government regulation and controls over questions such as labour practices, workplace safety and the impact of corporate activities on the environment. Companies' profitability often depends on eluding such unwelcome constraints. This is in addition to companies' perpetual motivation to minimize the sums they must pay in taxes. It is to be anticipated that many transnational corporations may perceive policies addressing social and environmental determinants of health as a threat, insofar as such policies might raise companies' production costs and impose additional regulations on their behaviour with regard to production processes, labour relations, environmental impacts and marketing practices.

Corporate interests likely to be made uncomfortable by an SDH agenda include powerful companies in the for-profit medical sector and the pharmaceutical industry. The pharmaceutical industry may regard the CSDH as threatening for two reasons: first, because an "upstream" preventive-promotive approach to health will not generate profits for the industry (and might indeed in the long run actually reduce demand for some of its products); second because of worries that the globalization and trade Knowledge Network or other organs of the Commission might publicly criticize the industry and/or generate policy recommendations seen as contrary to its interests.

Within international organizations and the development community

Institutions such as the World Bank and IMF have immense power to influence health and social policy in developing countries. The struggles of the Alma-Ata agenda in the 1980s offer, among other things, a lesson about what is likely to happen when health leaders recommend policies that are significantly out of step with the frameworks being promoted by the international financial institutions. To avoid a repetition of this scenario, the CSDH will need to manage its relationship with the IFIs and other major development institutions strategically. This may be a difficult challenge. While the IFIs' policy approaches have evolved since the 1980s, some analysts caution that the changes have been more on the level of rhetoric than of substance. The World Bank's acknowledgement of the importance of a strong, capable state¹³² and the presence of

new frameworks such as PRSPs do not necessarily signify changes in the underlying assumptions and imperatives of the neoliberal model. Critics argue that the asymmetrical power relationships between the IFIs and countries and the sorts of policy approaches recommended by the World Bank and IMF remain as before in many instances^{68,133}. The IFIs continue to advocate market liberalization and privatization, a "leaner" state and strict ceilings on public spending, including for health and social services. Their advice to countries may thus in many cases run counter to the policy approaches the CSDH will promote.

Moreover, both the IFIs and the bilateral development agencies of powerful countries are strongly influenced by corporate agendas. IFIs often act to advance the interests of corporations with close ties to their major shareholder governments. Thus to the extent the Commission's messages and policy advice are perceived as threatening to influential corporate constituencies, the IFIs and bilaterals may seek to discredit the Commission and its recommendations, either through public critiques or behind the scenes advice to national policymakers and other interlocutors. The CSDH may thus wish to consider advance outreach to key constituencies within the IFIs, bilaterals and other donor agencies as a special priority, developing and implementing targeted outreach strategies in the early phase of its operations.

IDENTIFYING POTENTIAL RESISTANCE: MAIN STRATEGIC QUESTIONS

- **To interest political leaders, a SDH policy agenda will have to offer opportunities for some "quick wins". This principle applies to country-level political processes and at the global level to the Commission itself. What might "quick wins" look like, for countries tackling social determinants and for the CSDH?**
- **How will the Commission develop its relationship with the major international financial institutions, in particular the World Bank?**

3.2.3 Identifying allies and political opportunities

The level of the Commission's success will depend to a considerable extent on its ability to construct a network of alliances and partnerships with influential actors at various levels, including: global institutions, national governments and policymakers, the business sector and civil society organizations. Fortunately, while the CSDH can expect to encounter resistance from certain influential constituencies (and must be prepared with appropriate strategies), the Commission will also enjoy distinctive opportunities. It will work in a political context which, if managed appropriately, offers chances for success beyond the reach of previous efforts. Arguably, Commissioners' most pivotal responsibility will be using their personal networks and links to various spheres of influence (political, business, academic, media, civil society) to build and maintain an expanding web of alliances that will support and publicize the Commission's work, disseminate its messages, and drive implementation of its policy recommendations. To be fully effective, this network must be operative on several levels simultaneously.

Global actors

Buy-in and ongoing support from major global institutions, including the relevant UN agencies, will be essential to creating sustained momentum around the SDH agenda and ensuring that it is durably integrated into international health policy and development models. The history of the PHC vs. SPHC debate in the 1980s suggests that the increasing divergence in strategy between WHO and UNICEF was a significant factor in weakening global commitment to the Health for All vision and to comprehensive PHC, with its intersectoral action component. Fortunately for the Commission, the SDH agenda appears strongly aligned with the current main thrust of UN and international development policy, built around the MDGs. Indeed, while certain aspects of the MDG programme are of course criticisable from a health perspective (absence of noncommunicable diseases, lack of explicit focus on health systems), the overall MDG framework provides an admirable opportunity both to secure the central place of health in development work generally and, more particularly, to promote understanding of the linkages between health outcomes and underlying social/economic/political conditions.

Most importantly, the MDGs by definition constitute a framework for coordinated international action, with commitment from major players already built in. To the extent the CSDH can align its policy recommendations with the MDGs, it can capitalize on the momentum of global and national commitment to the goals.

The work of the UN Millennium Project, whose final report was published in January 2005, has highlighted the interwovenness of the broad range of economic, health and environmental issues in international development under the MDGs⁸. A renewed sense of the urgent need for coordinated multisectoral action to improve the lives of the world's most vulnerable citizens has emerged, along with the model of a "global compact" between developed and developing countries that would dramatically increase investment in key sectors of direct interest to an SDH agenda, such as poverty and food security, education, women's empowerment, water and sanitation and living conditions in urban slums, as well as improved medical services⁷. The CSDH must give a high priority to positioning itself within the various international fora and policy processes connected with the MDGs, and to opening channels of dialogue with key players that can ensure that the CSDH is strongly profiled within these processes. Relevant fora and institutions would include the UN Economic and Social Council; the advisory teams around the UN Secretary-General; the Millennium Campaign effort; and the High Level Forum on MDGs; as well as the various UN specialized agencies contributing to the MDG effort and aligning their work according to MDG priorities.

The importance of outreach to the major international financial institutions has already been underscored. Contestation around the policies of the IFIs remains strong. Debates continue concerning the effects of PRSPs on developing countries' capacity to strengthen their health care systems and to implement social policies that promote health and health equity. Yet attitudes and practices at the World Bank and some regional development banks may be changing in ways that could facilitate the uptake of Commission messages and the implementation of CSDH-recommended policy measures. Importantly, the World Bank is publicly committed to the MDGs¹³⁴, and relations between WHO and the Bank have been strengthened through collaboration in the High-Level Forum on MDGs. Meanwhile, the

World Bank and IDB have been instrumental in the success of programmes such as Mexico's PROGRESA/Oportunidades. The profile the World Bank is now giving to equity as a key concern in international development¹³⁵ presents an opportunity for the CSDH to press its message that if countries and the global community are serious about attacking health inequities, the most effective way is via SDH.

A key strategic advantage for the CSDH, in comparison with efforts to promote intersectoral action on health determinants during the 1990s, is the strong and visible commitment to the SDH agenda from top leadership at WHO, including the Director-General. This high-level institutional buy-in within WHO increases the chances that an SDH approach to health policy design can be "mainstreamed" within WHO during the life of the Commission and can become a permanent dimension of the Organization's technical work and policy dialogue with Member States. On the other hand, across the global health community and even within WHO itself, some constituencies will certainly greet an SDH approach with scepticism. The architecture of the Commission and its Knowledge Networks, including special focus on health systems and diseases of public health priority, is designed to provide maximum chances to bring traditionally more biomedical constituencies "on board" with SDH, showing them how SDH approaches can improve results within their own programmes and contribute to the strengthening of integrated, sustainable health systems. A high-level WHO Reference Group linked to the Commission will develop a specific WHO-internal action agenda to incorporate the Commission's key recommendations into WHO policy and programming in a durable way.

International fora such as the G-8, regional bodies and more or less formalized political alliances around specific issues such as global hunger will also be key potential linkages for the Commission. The concern of the G-8 nations with economic and health inequalities offers an important entry point for the CSDH, which the Commissioners and their support staff should work to capitalize upon. African-led development initiatives such as NEPAD, though criticized in some quarters as excessively influenced by neoliberal models, signal creativity and fresh commitment to a comprehensive development approach that could offer opportunities for action on SDH. Development initiatives such as the global alliance against hunger recently launched by the

Presidents of Brazil, Chile, France and Spain relate directly to Commission themes and may enable synergies. The recent proposals by the UK on debt cancellation and a possible "Marshall Plan" for Africa also underscore the degree to which at least some sectors of the global policy and development community are willing to envisage new strategies and to weigh bold innovations.

National actors

At national level, the Commission begins its work at a time when, as noted above, momentum for concerted action on SDH is building. A number of politically and economically influential countries have enacted bold policies on SDH, and others may soon be ready to act. The problem of socially-conditioned health inequalities has emerged as an important political issue in an increasing number of jurisdictions⁸⁸. The most substantial policy advances have so far been made in high-income countries, but as the Oportunidades example shows, some developing countries are also introducing pioneering programmes. At the January 2005 session of the WHO Executive Board, strong endorsements of the CSDH were expressed by developing countries currently represented on the Board, including Bolivia, Ghana, Lesotho and Thailand. Many developing countries appear ready to consider serious, pragmatic proposals for policies and interventions that can reduce health inequality gaps through action on social factors.

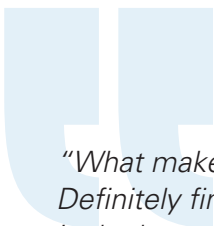
A close relationship to country-level processes and the policymakers involved in them will be vital for the Commission's success. Here again, Commissioners will make maximal use of their personal networks and will play a role that is above all political. An important function for the Commission will be brokering policy dialogue and knowledge-sharing between countries on the "leading edge" that have already enacted health policies addressing SDH and countries that want to implement such policies but have not yet done so and are seeking practical advice and insights on how to proceed.

The private sector

We have already discussed the challenge that may be posed to the CSDH by possible tensions between its messages and the interests of influential private sector actors, in particular transnational corporations. Clearly, finding appropriate modes of engagement with the business sector will be a major strategic concern for the Commission. Recommendations for structural change to reduce social inequality through large-scale, government-

led redistribution of resources are unlikely to find favour with the business community. However, certain intermediate-level policies and interventions aimed to improve health through action on SDH may indeed be appealing to private sector actors, and may enable the Commission to bring some industries and firms “on board” with CSDH proposals. The recent ILO-sponsored World Commission on the Social Dimension of Globalization, which included Taizo Nishimuro, Chairman of the Board of Toshiba Corporation, may provide lessons¹³⁶. Some policies and interventions recommended by the Commission can be cast as “business friendly”. For example, investment in early child development and in education is highly advantageous for creating the healthier, more skilled, more adaptable workforce required by many modern industries in the technology and service sectors. Likewise, housing improvement projects in urban slums could mean profits for the construction industry. Two recent reports on national business competitiveness (by the World Economic Forum and World Bank) have found Nordic countries to be among the world’s most competitive economies. These countries’ strong investments in social equity and programmes addressing SDH do not hinder their ability to compete in the global economy. On the contrary, according to an author of the World Bank study, “We found that social protection is good for business, it takes the burden off of businesses for health care costs and ensures a well-trained and educated work force”¹³⁷. Such findings may open up useful lines of argument for the CSDH.

On the other hand, deeper methodological and ethical questions underlie the issue of relations with the business sector and with governments anxious about the financial “bottom line”. The Commission must consider if and how to use cost-savings and cost-effectiveness arguments to promote health policies that embrace SDH. Recourse to such arguments could of course be quite advantageous when promoting SDH approaches to political decision-makers. As one senior policy adviser remarked in a recent workshop on evidence-based policymaking:



“What makes evidence talk? Definitely financial impact.... What is the best argument for getting government to listen? Answer: Money!”¹³⁸

As we have noted, the impact of the Commission on Macroeconomics and Health owed much to the CMH’s decision to justify its policy recommendations primarily in terms of economic gains, rather than via ethical arguments. Similarly, cost-savings arguments have been advanced by partisans of SDH policy approaches in a number of countries that have begun to implement or at least consider public health strategies oriented towards health determinants. Yet the scientific robustness of these arguments may be questionable. (Extending the lives of people over 50 will not necessarily result in substantial long-term savings for health systems; much of course depends on the type and quantity of health care and other services people require over their longer life-spans.). Is it economically credible to present SDH policies as tools that will enable governments and health systems to save money? Is it morally right to do so? The Commission will need to reflect carefully about how possible economic arguments for SDH policies relate to arguments based on equity, social justice and/or human rights.

Civil society

Since the pre-Alma-Ata era of community based health programmes, the active participation of civil society groups has regularly been cited as a key success factor, in cases where intersectoral policy on health determinants has worked well at local and national levels^{14,27,42}. Since the CSDH aims to generate results and not just words, it must take this correlation seriously and shape its strategies accordingly.

The CSDH may benefit from the evolving role of civil society at global, national and local levels. The influence of civil society organizations has grown in many parts of the world, as has the ability of such organizations to gather and share knowledge and to support each other’s efforts, increasingly linking across political and spatial boundaries through the use of new communications technologies^{139,140,141}. Civil society mobilization has been a crucial factor in some of the key political processes of recent years (from the toppling of apartheid to the “Orange Revolution” in Ukraine). In health, the impact of the Bangladesh Rural Advancement Committee (BRAC), South Africa’s Treatment Action Campaign and other civil society organizations has transformed traditional relationships between the medical establishment, government, industry interests and communities.

Several major international NGOs have expressed strong support for a SDH agenda, indeed some

**ALLIES AND POLITICAL OPPORTUNITIES:
MAIN STRATEGIC QUESTIONS**

- **How can the CSDH most effectively position itself within the global and national processes connected to the Millennium Development Goals (MDGs)?**
- **Is it scientifically credible, strategically desirable and/or ethically acceptable for the CSDH to argue that health policies tackling social determinants are a wise investment that will “pay off” in terms of enhanced economic performance and/or cost savings to health systems down the line?**
- **Can the CSDH operate strategically to get “buy-in” from the business community, without losing credibility with other key constituencies, including civil society? How will potential conflicts among these interests be mediated within the Commission as its work proceeds?**

did so well before the announcement of the Commission¹⁴². If the CSDH does engage civil society groups as active partners in the various phases of its work, the Commission can hope to harvest strength from the growing voice and influence of civil society in leveraging policy change and ensuring the translation of good ideas into concrete results. Recognizing the strategic importance of this issue, the CSDH secretariat is developing a comprehensive strategy for partnership with civil society organizations that will ensure space for civil society participation in all aspects of the CSDH process, including partner countries and Knowledge Networks. CSDH presence at the upcoming Second People’s Health Assembly in Cuenca, Ecuador, in June 2005, is one important step in opening a substantive dialogue.

3.2.4 Evidence, political processes and the CSDH “story line”

Scientific evidence is surely important to persuade constituencies sceptical about the value of health policy oriented to SDH. But evidence by itself it is rarely if ever sufficient to catalyse political action. In political terms, what may be at least as crucial as the evidence itself is the “story” in which it is embedded.

This idea is of course not new. Indeed, it is as old as politics itself. However, the importance of this theme has been strongly confirmed in recent public health history. The primary health care movement that arose in the 1970s was able to draw on evidence from successful community-based health programmes in the preceding decade. Yet what enabled PHC and Health for All to become the rallying cries of a global movement was not the evidence presented (which in the 1970s was relatively scant). What drove this change was the compelling narrative of justice, human flourishing and social transformation told by PHC’s proponents and embodied by the epic figure of Mahler. In the same way, the subsequent victory of selective PHC was less a matter of evidence per se than of shifting political interests coupled with the emergence of a new and in some ways even more compelling (because simpler) “story line”. This new story switched from a narrative about social justice to one focused on dying children and how quick action could save their lives. The SPHC narrative was essentially reducible to a set of “before and after” images often used in the promotion of the “child survival revolution”. The first showed a small child desperately ill with diarrhea, weak and dehydrated, the second the same child restored to vibrant life by the administration of oral rehydration salts¹⁴. The SPHC/GOBI story elided or glossed over many of the political and economic complexities with which the proponents of the Alma-Ata vision had tried to grapple. But precisely this elemental, human simplicity made the force and marketability of SPHC and the child survival agenda.

The importance of the story element to policy change in health has recently been confirmed by an intriguing research exercise. A team of leading public health experts studied the way scientific information is actually used (or ignored) in policymaking processes by exploring this issue in a qualitative residential workshop with senior policy advisers. Their findings should push public health scientists to renounce the belief that they can influence policy simply by providing government

officials with scientifically solid evidence. Policymakers interviewed for the study stressed the need for simple messages unclouded by jargon and argued that researchers should be more attentive to the timeframes within which governments operate. Sound evidence does not possess an inherent power to spur change, if it is not presented compellingly and in a timely manner, and if its relevance to decision-makers' current concerns is not made clear. Many policymakers emphasized the "value of a good story". As one UK health policy adviser observed:

"[What is important is] how convincingly the evidence is presented, and how interesting you make it. The face validity of a 'good story' is an example of how presentation style can influence politics"¹³⁸.

Participants argued that the importance of stories is not antithetical to the idea of evidence-based policymaking. As one informant stressed, it is not a case of either/or. "Stories themselves can be used in a credible way along with the evidence". Indeed, the story is the humanizing vehicle through which the evidence takes on its full significance.

A social determinants "story line" must be able to capture the attention of political decision-makers and other stakeholders, inspiring them with the sense that SDH are important and that action to address these factors is feasible and timely. It must enable and encourage policymakers to "sell" the SDH agenda to their colleagues and constituents. Creating and collectively "owning" this compelling, coherent story line is arguably the most important challenge facing the CSDH.

***A COMPELLING STORY LINE AND EVIDENCE:
MAIN STRATEGIC QUESTION***

▶ What story does the CSDH want to tell about social conditions and human well-being? What narrative will capture the imaginations, feelings, intellect and will of political decision-makers and the broader public and inspire them to action?

4 Conclusion

Today an unprecedented opportunity exists to tackle the roots of suffering and unnecessary death in the world's poor and vulnerable communities. The roots of most health inequalities and of the bulk of human suffering are social: the social determinants of health. Over the past decade, scientific knowledge on SDH has advanced dramatically, and today the political conditions for action are more favourable than ever before. This opportunity is too important to let slip away. To seize it will require leadership based on a mastery of the relevant science, but also moral vision and political wisdom. This is why the Commission on Social Determinants of Health has been constituted now.

This exceptional opportunity has emerged through a long historical process. Strongly affirmed in the 1948 WHO Constitution, the social dimensions of health were eclipsed during the subsequent public health era dominated by technology-based vertical programmes. The social determinants of health and the need for intersectoral action to address them reemerged in the Alma-Ata period, and were central to the model of comprehensive PHC proposed to drive the Health for All agenda. During this period, some countries made important strides in addressing key social determinants such as nutrition and women's education. However, like other aspects of comprehensive PHC, action on determinants was weakened by the neoliberal economic and political consensus dominant in the 1980s and beyond, with its focus on privatization, deregulation, shrinking states and freeing markets. Under the prolonged ascendancy of variants of neoliberalism, state-led action to improve health by addressing underlying social inequities appeared unfeasible in many contexts.

Recently, however, the tide has again begun to turn. The flaws of neoliberal policy prescriptions

have been exposed and the need for alternative development approaches widely recognized. Concern with health inequalities between and within countries has increased, while progress in the scientific understanding of the social determinants of health accelerated in the 1990s. In a growing number of countries this scientific evidence is being applied to shape bold new public policy approaches. For the moment, this trend remains largely concentrated in high-income countries, but several developing countries have begun to take innovative action on SDH, and more could be poised to do so. The Millennium Development Goals adopted by 189 countries in 2000 set a new integrated framework for global development that has once again focused attention on the interwovenness of development challenges and the need for simultaneous, coordinated action across a range of sectors including macroeconomic policy, food and agriculture, education, gender, and health. Without strong policy action on SDH, the health-related MDGs will not be attained in most low- and middle-income countries. This moment of "tidal shift" constitutes a historic opportunity for action on social determinants and a chance to change theory and practice about what constitutes *health policy* – as opposed to policies concerned with the delivery of health care services.

As the CSDH embarks on its mission, a sense of history will be a valuable resource. To maximize its chances of success, the Commission must craft its strategies with an awareness of past SDH efforts and the lessons these experiences can teach. This paper has attempted to provide a selective historical overview of major efforts to address SDH. It has traced in broad outlines the growth of knowledge on SDH and, equally important, some of the political dynamics that shaped efforts to intervene on the social dimensions of health and contributed to their success or frustration. The paper has not tried to offer prescriptions.

It will have fulfilled its function if it brings into clearer focus some of the urgent issues with which the Commissioners must grapple, as the CSDH establishes its identity, fixes its objectives and frames its strategies.

In conclusion, we recall the 8 key strategic questions identified:

- ① How will the CSDH position itself on the “Mahler-Grant problem”: i.e., choosing (or compromising) between: (1) a far-reaching structural critique based on a social justice vision and (2) promoting a number of tightly focused interventions that may produce short-term results, but risk leaving the deeper causes of avoidable suffering and health inequities untouched? If a more comprehensive, values-oriented approach is taken, the CSDH may sacrifice short-term efficacy and measurable results. If a more selective, intervention-focused, pragmatic stance is adopted, critics may well wonder why a global Commission was required for this job, rather than a much less costly technical working group. This issue fundamentally concerns how Commissioners understand their *political* role, and the place they assign to moral values in an undertaking that aims to leverage policy action and bring concrete, measurable results rapidly.
- ② What evaluation structure will the CSDH put in place to identify appropriate policy entry points for different countries/jurisdictions?
- ③ To interest political leaders, a SDH policy agenda will have to offer opportunities for some “quick wins”. This principle applies to country-level political processes and at the global level to the Commission itself. What might “quick wins” look like, for countries tackling social determinants and for the CSDH?
- ④ How will the Commission develop its relationship with the major international financial institutions, in particular the World Bank?
- ⑤ How can the CSDH most effectively position itself within the global and national processes connected to the Millennium Development Goals (MDGs)?
- ⑥ Is it scientifically credible, strategically desirable and/or ethically acceptable for the CSDH to argue that health policies tackling social determinants are a wise investment that will “pay off” in terms of enhanced economic performance and/or cost savings to health systems down the line?
- ⑦ Can the CSDH operate strategically to get “buy-in” from the business community, without losing credibility with other key constituencies, including civil society organizations? How will potential conflicts among these interests be mediated within the Commission as its work proceeds?
- ⑧ Drawing together all these and other issues is the question of “story”. This is not a mere footnote to the scientific and political problems the Commission must confront, but is at the heart of the CSDH’s effort to catalyse change. What *story* do the members of the CSDH collectively want to tell about social conditions and human well-being? What narrative will capture the imaginations, feelings, intellect and will of political decision-makers and the broader public and inspire them to action?

List of abbreviations

CCSS	<i>Caja Costarricense del Seguro Social</i> (Costa Rica)
CBHP	community-based health programmes
CMH	Commission on Macroeconomics and Health
CSDH	Commission on Social Determinants of Health
G-8	Group of Eight Nations
GHLC	<i>Good health at low cost</i> (Rockefeller Foundation)
GOBI	growth monitoring, oral rehydration, breastfeeding, immunization
HAZ	Health Action Zones (United Kingdom)
HFA	Health for All
HIPC	Heavily Indebted Poor Countries Initiative
HSR	health sector reform
IAH	intersectoral action for health
IMF	International Monetary Fund
IFIs	international financial institutions
MoH	Ministry of Health
MDGs	Millennium Development Goals
NGO	nongovernmental organization
PHC	primary health care
PRSP	Poverty Reduction Strategy Paper
RHP	Rural Health Programme (Costa Rica)
SAPs	structural adjustment programmes
SDH	social determinants of health
SPHC	selective primary health care
UK	United Kingdom
UN	United Nations
UNICEF	United Nations Children's Fund
USA	United States of America
WHA	World Health Assembly
WHO	World Health Organization
WTO	World Trade Organization

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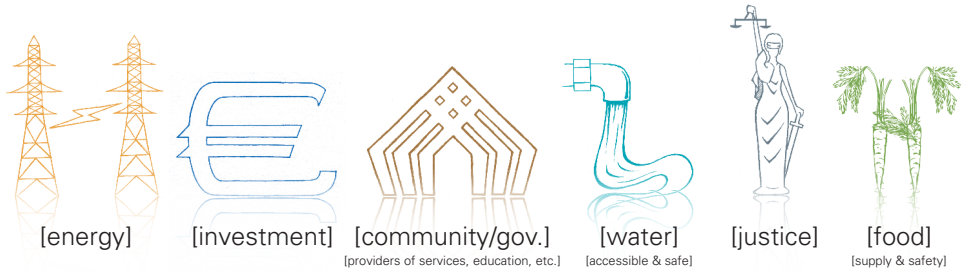
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SOCIAL DETERMINANTS OF HEALTH

ACCESS TO POWER, MONEY AND RESOURCES AND THE CONDITIONS OF DAILY LIFE —
THE CIRCUMSTANCES IN WHICH PEOPLE ARE BORN, GROW, LIVE, WORK, AND AGE



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