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Revisiting the social determinants of health agenda from the global South

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ABSTRACT

In an effort to provide an overview of the conceptual debates shaping the mobilisation around social determinants of health and health inequities and challenge the apparent consensus for equity in health, this essay compares two of the most influential approaches in the field: the WHO Commission on Social Determinants of Health approach (CSDH), strongly influenced by European Social Medicine, and the Latin American Social Medicine and Collective Health (LASM-CH) 'Social determination of the health-disease process' approach, hitherto largely invisibilized. It is argued that the debates shaping the equity in health agenda do not merely reflect conceptual differences, but essentially different ethical-political proposals that define the way health inequities are understood and proposed to be transformed. While the health equity agenda probably also gained momentum due to the broad political alliance it managed to consolidate, it is necessary to make differences explicit as this allows for an increase in the breadth and specificity of the debate, facilitating the recognition of contextually relevant proposals towards the reduction of health inequities.

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Introduction

One of the most marked characteristics of the global social structure is the existence of substantial inequalities in wealth and income, which also find expression in differences in health between countries and between social groups within countries (Berkman, Kawachi, & Glymour, 2014; Dorling & Barford, 2007). While many countries have experienced sharp reductions in absolute poverty and excess mortality (Victora et al., 2011), inequities in health persist across countries and reflect historically defined and territorially specific expressions of structural conflictuality in the capitalist accumulation and production regime (Piketty, 2014; Sanahuja, 2013; Wallerstein, 2011) along the lines of class, race/ethnicity and gender as well as the global North/South divide. This patterning is evident in infant mortality rates varying between 2 per 1000 live births in Iceland and over 120 per 1000 live births in Mozambique, the 28 year difference in life expectancy at birth for men of two Glasgow neighbourhoods or the fact that in the United States, 886,202 deaths could have been averted between 1991 and 2000 if mortality rates between white and African Americans were equalised, contrasted to 176,633 lives saved in the US by medical advances in the same period, just to name a few examples (CSDH, 2007).

In recent decades, international health agendas have tended to oscillate between two main approaches: (1) narrowly defined, technology-based medical and public health interventions; and (2) an understanding of health as a social phenomenon, proposing more complex forms of

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intersectoral policy action, and sometimes linked to a broader social justice agenda (Solar & Irwin, 2010). The latter found expression in the celebrated Alma Ata Conference from 1978 and the Primary Health Care Agenda, the Ottawa Charter for Health Promotion (1986), and more recently, in the work of the WHO Commission on Social Determinants of Health (CSDH), the adoption of the Rio Political Declaration in 2011, following the World Conference on Social Determinants of Health in Rio de Janeiro as well as in the Health in All Policies Framework and the Lancet-University of Oslo Commission on Global Governance for Health. Although health and social security system reforms over the last two decades have been dictated by a neoliberal agenda shaped by the convergence of the World Health Organization, international financial institutions, and transnational corporations (Armada, Muntaner, & Navarro, 2001; Hernández, 2003), particularly in Latin America, and strict fiscal austerity following the 2008 economic crisis currently strain and erode Southern European health and social security systems (Karanikolos et al., 2013), the health equity question is notably present in the international health agenda and public discourse.

The publication of the final report of the WHO CSDH in 2008 evinced the renewed interest and political will to address health inequities, constituting a crucial advance in the mobilisation for health equity by making a case for the urgent need for comprehensive action and by drawing attention to government responsibility. The conceptual framework of the Commission and policy directions for action implied by the proposed SDH approach became a key reference and driver of the global health equity agenda (Birn, 2009; Cabrera et al., 2011); also because it offered an overdue and yet not overly radical critique of the prevailing social, economic and political order at a time when it was no longer possible to hide away or deny the negative consequences the growth oriented development model – at the core of the prevalent social, economic and political order - has for human well-being, environment and health.

Nonetheless and despite the fact that the SDH approach was presented and celebrated as a globally consented proposal and new opportunity to improve health and tackle inequities (Friel & Marmot, 2011; Solar & Irwin, 2006), three alternative declarations were published following the adoption of the Rio Political Declaration in 2011, which several commentators (Birn, 2009; Borde, Porto, & Hernández, 2015; Breilh, 2011b; Cabrera et al., 2011) understand as an expression of the dissatisfaction, and primarily, of differences in the way social determinants of health and health inequities are understood. That is to say, different ethical-political proposals on social justice, equity, policy action and emancipation, that define how social determinants of health and health inequities are conceived, conceptualised, researched and proposed to be transformed, and consequently mobilise different political, social and economic agendas.

The declarations respectively emitted by the International Federation of Medical Student Associations (IFMSA), the People's Health Movement (PHM) and the *Asociación Latinoamericana de Medicina Social* (ALAMES)/*Centro de Estudos Brasileiros sobre a Saúde* (CEBES), in this regard made the existence of alternative proposals visible and showed how the call for health equity is less unequivocal than it may seem. Furthermore, it was shown that it is necessary to better differentiate to further qualify the debate and to provide a critical historical perspective on the proposed scope and concrete opportunities for action on social determinants of health and health inequities.

In an effort to provide an overview of the conceptual debates shaping the mobilisation around social determinants of health and health inequities and challenge the apparent consensus for equity in health, this essay exemplary compares and contrasts two of the most influential approaches in the field: the WHO Commission on Social Determinants of Health approach (CSDH), strongly influenced by European Social Medicine, and the Latin American Social Medicine and Collective Health (LASM-CH) 'social determination of the health-disease processes' approach, hitherto largely invisible in the dominant global agenda for health equity and in the mobilisation around SDH and health inequities.

Methods

The essay draws on a review of published and unpublished literature on social determinants of health and health inequities in English, Spanish and Portuguese, retrieved between February 2015 and December 2017 from the following automated search engines: PubMed, LILACS, VHL, Google Scholar and Scielo. Furthermore, bibliography was manually selected based on the criteria of the authors.

We begin by providing an overview of the conceptual debates shaping the dominant equity in health agenda and introduce the WHO Social Determinants of Health (SDH) approach to illustrate how social determinants of health and health inequities are conceived, conceptualised, researched and proposed to be transformed according to this agenda. In the second part, the WHO SDH approach is compared and contrasted with the Latin American Social Medicine and Collective Health (LA SM-CH) 'Social determination of the health-disease-care process' or short, 'social determina*tion* of health' approach, which has been developing over the last 50 years in Latin American Social Medicine and Collective Health and has been discussed and recognised as an alternative and yet mostly undervalued and invisibilized approach to address health inequities (Birn, 2009; Borde et al., 2015; Spiegel, Breilh, & Yassi, 2015; Tajer, 2003).

Debates shaping the dominant equity in health agenda

Several developments, debates and theories have shaped the mobilisation around social determinants of health and health inequities over the years and constituted a global health equity agenda. Apart from external economic, social and political pressures that defined the scope and relative dominance of the agenda for health equity at different points in time, the agenda expresses internal mediations and, essentially, choices on ontological, epistemological and praxiological proposals. These choices, and more so the relative dominance of specific ontological, epistemological and praxiological stances in the global agenda for health equity are rarely discussed and often limited to rather linear accounts on the historical development of a specific agenda or a specific field of research. In this regard, it seems necessary to recognise the dialectics of dominance/subalternity and visibility/invisibility in the global agenda for health equity and in science in general, recognising differences and conflicts between different approaches to better understand the apparently subtle discursive and theoretical shifts that orchestrate often profound political, social and economic changes.

In the following, we will review theories and approaches that are recognised in and have defined the global health equity agenda and will then exemplify the discussion in relation to two approaches. In this regard, we will critically analyze the way social determinants of health and health inequities are conceived, conceptualised, researched and proposed to be transformed according to the dominant SDH approach promoted by the WHO CSDH and will then contrast it with the LA SM-CH 'social determination of the health-disease process' approach, addressing key concepts and discussions that have shaped this approach and LA SM-CH in general.

It is important to note that despite the fact that we are proposing to compare and contrast the SDH approach and the LA SM-CH 'social determination of the health-disease process' approach, both approaches share the recognition of health as a human and social right and goal, the need for intersectoral action for health and the condemnation of health inequities, amongst others, and although to different degrees, both constitute a rupture in relation to more traditional, conservative public health approaches based on narrowly defined, technology-based interventions and the naturalisation of health inequities based, for example, on biological essentialism consisting of a belief that certain phenomena are natural, inevitable and biologically determined.

Defining the dominant global health equity agenda

The CSDH conceptual framework recognises three not necessarily mutually exclusive theoretical directions in current social epidemiology which seek to elucidate principles capable of explaining

social inequalities in health: (a) psychosocial approaches, (b) ecosocial theory and related multi-level frameworks; and (c) social production of disease/political economy of health (Solar & Irwin, 2010, p. 15). Psychosocial approaches proposed by Cassels (1976) and Wilkinson & Pickett (2006), amongst others, ascribe the existence of health inequalities to the direct or indirect effects of stress, arguing that the exposure to adverse psychosocial environments, for example at the workplace (high demands, low control and or effort-reward imbalances), elicits sustained stress reactions with negative (long-term) consequences for health (Kawachi, Subramanian, & Almeida-Filho, 2002; Solar & Irwin, 2010). Direct and indirect effects of stress are recognised and it is suggested that the exposure to daily adverse life circumstances creates wear and tear on the organism through allostatic loads. Furthermore, stress may affect health by promoting a more adverse profile of behaviours such as smoking and excessive alcohol consumption (Kawachi et al., 2002). It is argued that these exposures are likely to be experienced more frequently among lower socioeconomic groups and that the extent of the effects on health produced by such exposures may be greater in lower socioeconomic groups, which are considered more vulnerable and less resistant to stressors due to arguably weaker social cohesion and disintegration of social bonds. Krieger (2001b) accordingly concludes that a psychosocial framework

> 'directs attention to endogenous biological responses to human interactions. Its focus is on responses to "stress" and on stressed people in need of psychosocial resources. Comparatively less attention is accorded both theoretically and empirically to: (1) who and what generates psychosocial insults and buffers, and (2) how their distribution – along with that of ubiquitous or non-ubiquitous pathogenic physical, chemical, or biological agents – is shaped by social, political and economic policies'. (Krieger, 2001b, p. 670)

The ecosocial approach and related multi-level frameworks integrate social and biological factors and propose a dynamic, historical and ecological perspective to develop new insights into determinants of population distribution of disease and inequities in health (Solar & Irwin, 2010). Analyses of population patterns of health, disease and well-being are analyzed in relation to different levels of biological, ecological and social organisation and embrace a social production of disease perspective while aiming to complement macro-level analyses with biological and ecological analysis.

> "Thus, more than simply adding "biology" to "social" analyses, or "social factors" to "biological" analyses, the ecosocial framework begins to envision a more systematic integrated approach capable of generating new hypotheses, rather than simply reinterpreting factors identified by one approach (e.g. biological) in terms of another (e.g. social)'. (Krieger, 2001b, p. 673)

Krieger's notion of 'embodiment' is central to this approach and describes how the material and social world finds expression in and shapes our biology. According to this approach pathways of embodiment are structured by (a) societal arrangements of power and property and patterns of production, consumption and reproduction as well as by (b) constraints and possibilities of biology, shaped by evolution, the ecological context and individual and family trajectories of biological and social development (Krieger, 2001a).

In social production of disease/political economy of health approaches, economic and political determinants of health and disease are emphasised, understanding inequalities in health between social groups as expressions of the social organisation characteristic of the capitalist accumulation and production regime and related processes of exploitation, oppression and marginalisation (Kaplan, Pamuk, Lynch, Cohen, & Balfour, 1996; Lynch et al., 1998). In this regard, it is recognised that diseases are socially produced and distributed and that the very way in which disease is treated is itself an aspect of capitalist society in the sense that disease is individualised and depoliticised and essentially geared towards the generation of profit. The social organisation and the processes that produce and reproduce this organisation accordingly become central to the analyses proposed by these approaches, addressing questions such as: 'how does prioritizing capital accumulation over human need affect health, as evinced through injurious workplace organization and exposure to occupational hazards, inadequate pay scales, profligate pollution, and rampant commodification of virtually every human activity, need, and desire?' (Krieger, 2001b, p. 670). The underlying

hypothesis is that economic and political institutions and decisions that create, enforce, and perpetuate economic and social privilege and inequality along the lines of class, gender and ethnicity/race are root causes of social inequalities in health (Krieger, 2001b, p. 670), which implies that reducing inequalities in health requires changes in the social and economic order.

While the Latin American Social Medicine and Collective Health 'social determination of the health disease-process' approach is often subsumed under social production of disease/ political economy of health approaches (Krieger, 2001a, 2001b; Solar & Irwin, 2010), though rarely properly recognised or referenced in English language publications, we argue that the LA SM-CH approach constitutes a different theoretical direction, which synthesises social production of disease/ political economy of health approaches and ecosocial approaches but introduces yet other constructs and ways of addressing inequities in health – ontologically, epistemologically and praxiologically – which do not neatly fit into the previously outlined theoretical directions. This is particularly so as the Latin American Social Medicine and Collective health approaches developed in Latin America – with other geo-cultural and epistemological references that developed within a distinct and largely subordinated genealogy of critical thought, undoubtedly strongly influenced by Marxist approaches but also by the works of Bourdieu and Foucault, particularly in Brazil.

The WHO CSDH or SDH approach, in contrast, does not constitute a radical rupture but rather synthesises the above outlined theoretical directions and essentially, the Anglo-Saxon European Social Medicine, primarily based on the CSDH´s chair Sir Michael Marmot and his colleague's work. While this is not explicitly recognised and the SDH approach has substantially defined the global equity in health agenda, it has been noted by several commentators (Breilh, 2011b; Guzmán, 2009; Lynch et al., 1998; Morales-Borrero, Borde, Eslava-Castañeda, & Concha-Sánchez, 2013) and is evident in the ontological, epistemological and praxiological proposals that constitute the SDH approach. In the following, the CSDH SDH approach will be critically analyzed and contrasted with the LA SM-CH SD approach.

The dominant equity in health agenda and the SDH approach

In recent years, the dominant health equity agenda particularly found expression in the WHO SDH approach. The SDH approach and the final report of the CSDH make several important contributions and have undoubtedly strengthened the global health equity agenda, documenting the existence and consequences of health inequities within and between countries. Nonetheless, there are several shortcomings that will be discussed in the following and in the next section contrasted to alternatives invoked by the LA SM-CH social determination of the health-disease-care process approach.

The CSDH proposes a model which differentiates between two types of social determinants of health: structural determinants and intermediary determinants. Structural determinants are those that generate or reinforce social stratification in the society and that define individual socioeconomic position, configuring health opportunities of social groups based on their placement within hierarchies of power, prestige and access to resources (economic status) (Solar & Irwin, 2010, p. 30). The socioeconomic position is primarily shaped by occupational status, educational achievement and income level and also the role of gender and ethnic/racial discrimination is recognised, which are all proposed to be measured at individual, household and neighbourhood level and at different points of the lifespan. The authors of the CSDH conceptual framework further recognise contextual factors including: culture and social values, public policies on education, medical care, water and sanitation, social policies affecting factors such as labour, social welfare, land and housing, macroeconomic policies, governance mechanisms related to the definition of needs, patterns of discrimination, civil society participation, accountability and transparency in public administration, and epidemiological conditions including epidemics that alter the social structure, such as HIV/Aids (Solar & Irwin, 2010, p. 25).

The intermediary determinants of health flow from the configuration of underlying social stratification and determine differences in exposure and vulnerability to health-compromising conditions and include the following factors: material circumstances; psychosocial circumstances; behavioural and/or biological factors; and the health system itself (Solar & Irwin, 2010, p. 36). Material circumstances are linked to the physical environment such as housing, consumption potential and the physical working and neighbourhood environment. Psychosocial circumstances refer to different degrees of exposure to experiences and life situations that are perceived as threatening and difficult according to socioeconomic status, including job strain, high debt and lack of social support. The authors of the CSDH conceptual framework further recognise social differences in behavioural/lifestyle factors related to nutrition, physical activity, tobacco and alcohol consumption (Solar & Irwin, 2010, p. 39). The health care system is recognised as a social determinant of health in the sense that it can directly address differences in exposure and vulnerability by improving equitable access to health care and promote intersectoral action to improve health status, as the authors of the CSDH conceptual framework note (Solar & Irwin, 2010, p. 40).

While the SDH approach identifies social conditions in which people are born, live and work and claims that 'social injustice is killing people on a grand scale' (CSDH, 2007), the CSDH analysis and conceptual framework concentrate on what society produces in terms of inequalities and reduce the scope of the critique to what is more than evident, particularly in the global South and increasingly in the global North, failing to clarify the causes of the 'causes of the causes', that is, the processes that historically created and systematically reproduce inequities (Birn, 2009; Navarro, 2009). In this regard, the final report extensively documents inequalities in health between and within countries and provides scientific foundation for appreciating the role of social factors in health, but does not make explicit why and in which way educational achievement, income level, racial/ethnic discrimination, occupational status and gender discrimination structurally determine health across the world. Considered as an 'interplay between the socioeconomic-political context, structural mechanisms generating social stratification and the resulting socioeconomic position of individuals' (CSDH, 2007), the 'social determinants of health inequities', that is, 'structural determinants of health' remain vague, decontextualised and essentially individual, conveying an idea of social 'risk' factors that affect individuals according to their position in the social hierarchy and engender in what the CSDH euphemistically calls 'market-driven globalization'. Accordingly, health outcomes are associated with social stratification and specifically with structural determinants such as income level, ethnicity/race and educational achievement but in the absence of a comprehensive analysis of society, of power relations in society and the processes in which these determinants develop and are reproduced, barely serve as markers of inequities between individuals rather than social groups and become descriptive factors rather than analytical categories of societal characteristics (Breilh, 2011a; Starfield, 2006).

In this regard and although market forces and globalisation are recognised as social determinants of health inequities, the CSDH consistently 'refrains from referring to global capitalism' (Birn, 2009, p. 179) and in this same line, transforms 'social class' into 'socioeconomic status' or 'income level' and 'racism' into ethnic and racial 'discrimination', just to name a few examples. While the CSDH conceptual framework (Solar & Irwin, 2010) does offer theoretical foundations for each of the social determinants proposed in the SDH model, there is no discussion on political struggle, oppression and exploitation, that is, social processes that generate and substantiate unequal power relations in capitalist development models, let alone alternatives to capitalist development. The market and globalisation accordingly appear as obscure and abstract forces that present failures and produce inequalities (Cabrera et al., 2011), which can, however, be corrected with redistributive policies, good governance and by making the market responsible (CSDH, 2007). The CSDH in this regard proposes to 'heighten public health representation in economic policy negotiations, anchored by the institutionalization of health equity impact assessment (HEIA) in all national and international policies and economic treaties' (Birn, 2009, p. 173). Both proposals certainly make interesting and yet blatantly insufficient proposals that imply a rather random, accidental and unforeseen impact of 'the

market' on health and health equity, omitting the systematic pattern of social determination engendered in the context of the extreme exploitation of labour and of nature in capitalist accumulation and production regimes. In this regard, there is no recognition of the incompatibility of this regime with healthy lives and the CSDH is content with improvements in an inherently unjust system (Breilh, 2011a). The horizon of transformation is accordingly limited to the correction of distortions that the system presents, without contesting and confronting it (Breilh, 2011a, p. 48), reserving a privileged role for redistributive government policies.

The CSDH imagines a social mobilisation for equity in health and departs from the supposition that the recognition of the scope of inequalities in health is reason enough to mobilise local and national authorities and civil society. This conveys a rather naïve understanding of policy making and of drivers of societal change, which is particularly evident in the discussion of the Northern European welfare states in the CSDH final report, presented and glorified with no mention of the political struggles that were needed to consolidate such systems, let alone the historically shaped structures of exploitation, contributing to the viability and acceptance of such systems in these parts of the world, while similar efforts are being systematically eroded in the global South. Similarly, following Birn (2009), the low and middle income countries that have achieved a level of good health and managed to reduce inequities despite their level of national income and are proposed as examples by the CSDH, all passed through

> long-term political struggle whether arising from armed revolution (in the case of Cuba), […] a long and ongoing struggle for left-wing political parties to be elected and re-elected to office (in Kerala); or strong populist and labor movements favoring social protections, an end to military spending following a brutal civil war, and the fending off of imperialist interests (in Costa Rica). (Birn, 2009, p. 175)

These omissions seriously hamper a comprehensive understanding of the structural drivers of health equity and weaken the call for 'social participation' and 'empowerment', central to the SDH approach. In this regard, both concepts remain superficial and fixed to an idea of civil identity, liberty and autonomy, subject to a similarly vain understanding of 'political will'. The history of public health and even the review of historical trajectories forging the equity in health agenda proposed in the CSDH conceptual framework (Solar & Irwin, 2010) and in the final report (CSDH, 2007) show social mobilisation to be the key factor that has rendered governments accountable and responsive and has brought about societal transformations, the SDH approach continues to privilege technical solutions focusing on policy makers, questions of governance and a strong belief in the possibility of and need for 'win-win' solutions, driven by false pragmatism and a skewed understanding of politics that render politics apolitical and naturalise relationships shaped by asymmetrical power relations. Similarly, the role of social movements is downplayed and reduced to a functional and hollow understanding of civil society participation (Breilh, 2011a).

The CSDH is unequivocal in the defense of universal health systems and calls for resurrecting the state's role in providing health services, invoking the government responsibility to respect, protect and fulfil the human right to health (Birn, 2009) – a claim that has also mobilised Latin American SM-CH. And yet, contradictory or not, several of the CSDH commissioners have been at the forefront of the universal health *coverage* (UHC) agenda (Andrade et al., 2015; Marmot, 2013), transforming the call for universal health systems into a call for universal health coverage, which represents a significant retreat and implies essentially different ethical-political proposals, as Heredia et al. (2015) point out. In this regard Heredia et al. (2015) argue that it is critical to distinguish forms of health insurance – be they voluntary or compulsory and public or private – from a unified tax-funded public health system and contrast the experiences in Chile, Mexico and Colombia with that of Brazil and Cuba and, more recently, Venezuela, Bolivia and Ecuador, which adopted constitutionally guaranteed reform models amidst broad social mobilisation, and in the case of Bolivia and Ecuador in the phase of rethinking and restructuring the State according to an alternative development paradigm anchored in the indigenous principle of 'living well' (Sumak Kawsay) (Breilh, 2010; Breilh & Muñoz, 2009), with all the contradictions that this transition involves (Radcliffe, 2012).

These discursive shifts are not a minor issue and in the context of the historical retreat, for example, from Primary Health Care to Selective Primary Health Care, they underline the need to carefully differentiate and dissect the ethical-political foundations of the respective proposals. This requires an analysis of the concrete possibilities that actors, commissions and reports have, which would, for example, explain but not necessarily justify why the CSDH final report is notably more politically timid than the CSDH conceptual framework. Further, and as recognised by Birn (2009, p. 174) in relation to the way the CSDH addresses the role of the private sector and the lack of accountability of large philanthropies, this may imply understanding that it 'may be too impolite and impolitic' for the WHO CSDH to explicitly call for the disempowerment of the private sector and political allies to wield 'benign' influence. And yet, Birn (2009) rightly asserts that the report could and 'should certainly refrain from its assertion that health equity will be achieved with the collaboration of private actors' (Birn, 2009, p. 174).

Nonetheless, the CSDH conception seems to reflect a conviction and wish of health equity advocates shaping the dominant equity in health agenda, that it is possible and necessary to get the private sector on board and furthermore, to generate win-win scenarios, coherent with the consistent failure to match groups needing empowerment against those who wield excessive power and to seriously engage with the dialectics of oppressor-oppressed and privilege-benefit, amongst others, and to transcend polarizations, deemed outdated and unrealistic (Birn, 2009).

Social determination of the health-disease-care process

The Social Determination of the Health-Disease-Care Process is developing as part of Latin American Social Medicine and Collective Health (LA SM-CH), a stream of thought and a movement that evolved in three phases, with the *early formative period* dating back to the 1960s and 1970s (Almeida-Filho & Paim, 1999; Breilh, 2008; García, 1994; Laurell, 1994) and being primarily influenced by labour health demands as well as critical analyses of the epistemological foundations of modern epidemiology and traditional public health. Cecilia Donnangelo (Donnangelo & Pereira, 1976), Jaime Breilh (1986), Sergio Arouca (2003), Edmundo Granda (1989), Asa Cristina Laurell (1979) and Ricardo Bruno Mendes-Gonçalves (Santos & Ayres, 2017) arguably made the most notable contributions during that phase, addressing issues as diverse as medical practice and formation, workerś health and the epistemology of modern epidemiology. Breilh (2008) self-critically recognises these early works, particularly those of himself and his direct colleagues, as being overtly state-centered and based on a unicultural theoretical matrix, possibly necessary to position social class inequity in epidemiological and public health research agendas, but clearly insufficient to capture processes of social determination of the health/disease/care process. In the advent of neoliberalism and structural adjustment programmes during the 1980s and 1990s, the need for organisational structures became evident and LA SM-CH organised around national organisations such as ABRASCO, CEBES, CEAS and particularly around the *Asociación Latinoamericana de Medicina Social* (ALAMES), which was founded in 1984, premised on the defense of health as a public good and civil right and as a social, political, and academic movement. In this period it was recognised that it was necessary to diversify the study of inequity and understanding the linkages between social class, ethnic and gendered power relations shaped by macro-economic processes and the social determination of health (|Breilh, 1986, 2008), evolving into a *second period*. Regarding this period Breilh (2008) notes that 'an immediate challenge was to deconstruct the official discourse of conservative multiculturalism and of culturally relativistic interpretations of health problems, which worked parallel to the neoliberal political economy to justify the dissolution and decentralization of public health epidemiological programmes' (Breilh, 2008, p. 747). The Brazilian health reform undertaken during the 1980s and culminating in the consolidation of the constitutionally guaranteed Unified Health System (*Sistema Único de Saúde* – SUS) in 1988, became an important inspiration for the Latin American SM-CH and essentially represented a synthesis of the proposals of the movement (Escorel, 2009). During the last decade and *third period*, the idea of an alternative subjectivity and of

critical interculturality matured, integrating indigenous people's movement demands for emancipatory intercultural knowledge and the Marxist concept of subjectivity that recognises the subject as historically conditioned and at the same time a maker of history (Tajer, 2003). During that time graduate and postgraduate programmes in Social Medicine and Collective Health were consolidated across the region, particularly in Brazil, Argentina, Ecuador, Colombia, Venezuela and Mexico.

Although it is clear that LA SM-CH does not constitute a single, monolithic block and has rather been characterised by constant renovation and diversity, there are some unifying and distinctive elements, that will be outlined in the following.

LA SM-CH movement has historically recognised the need to intertwine processes of transformation on ontological, epistemological and praxiological level – rethinking health and health inequities as theoretical objects; innovating the way these are conceptually and methodologically addressed and projected in praxis. In this regard, there have been comprehensive efforts to rethink health, seeking to overcome the dichotomy of biomedically defined health and disease towards an understanding of health as a complex, multidimensional and essentially social process (Almeida-Filho, 2001; Coelho & Almeida-Filho, 2002), translating into the 'consideration of the dialectic relation between being healthy, being sick, and health care practices, not as unrelated situations but as a historical process described as the health-disease-care process' (Tajer, 2003, p. 2024). Consequently, LA SM-CH has proposed to understand health as a complex social process in as far as it cannot be disconnected from the societal arrangements within which these processes evolve. Rather than an association between society and individual-level biology, the health-disease-care process is understood and conceptualised as part and expression of society. It is in this regard that Breilh (2010) speaks of the 'social determination of health and life', arguing that measures to improve health will not be complete unless they are articulated with the defense of life, primarily the environmental integrity necessary for human survival. Breilh (2010, 2013) accordingly speaks of the ethics of life and health based on the four 'Ss' of a healthy life (sustainability, sovereignty, solidarity and health/holistic biosecurity), which leads the author to affirm that the prevailing capitalist accumulation and production regime is incompatible with health and life. This applies as

> 'the contemporary capitalist logic not only exerts itself through the extraction of surplus value from workers and the traditional market mechanisms, but now depends heavily on truly predatory forms of practice, fraud and violent extraction, which are imposed by taking advantage of inequalities and power asymmetries to dispossess weaker countries or vulnerable groups directly. (Breilh, 2005)

Capitalist societies are accordingly recognised as being shaped by a concentration of power and particularly by a 'triple inequity', which defines the intersection of class, gender and ethnicity/race oppressions that shape social structure and define the quality and scope of oppression, exploitation and marginalisation individuals and social groups suffer under this regime. It is argued that only by considering these processes can categories like gender, ethnicity and social class have analytical value and can individual specificities such as sex, age, income level or educational achievements have explanatory relevance. This is intimately linked to the ontology of health inequities and inversely the way equity in health is understood, remitting to ethical considerations around justice.

The liberal notion of justice has been dominant during the last 30 years (Hernández, 2003, 2011) and has shaped and reproduced the capitalist accumulation and production regime, particularly driving 'market fundamentalism' as social, economic and cultural rights are not strictly considered as rights, but rather as commodities. This also applies to health, defined as a private responsibility and to health care, understood as a private good. Justice accordingly primarily translates into the respect for the rights of individuals, namely property and possession rights as well as the right to freedom, particularly to be at liberty to make rational choices. In this same line of reasoning, society is understood as a set of individuals or rational agents, essentially ahistorical subjects without sociocultural roots (Benhabib, 1992), which interact and seek to maximise personal utility.

The WHO CSDH distances itself from the liberal notion of justice and following Amartya Sen, recognises health as a 'special good'. Inequalities in health are thus recognised as 'inequalities in

people's capability to function' which substantiates the conceptualisation of health equity as the absence of unfair and avoidable/remediable differences in health among social groups (Solar & Irwin, 2010). Health is accordingly seen as a prerequisite for individual agency and freedom and reversely, greater agency and freedom are considered to yield better health (Solar & Irwin, 2010, p. 12). By explicitly assuming 'the human rights framework as the appropriate conceptual structure within which to advance towards health equity through action on SDH' (Solar & Irwin, 2010, p. 12), the CSDH removes actions to promote health equity from the voluntary realm of charity to the domain of law and calls on national governments to assume the responsibility for protecting and enhancing health equity. In this light, reversing inequities in health translates into equipping individuals with greater 'possibilities of control over their health' (Solar & Irwin, 2010). Equity in health accordingly requires minimising avoidable disparities in health and its determinants between groups of people who have different levels of underlying social advantage due to their position in society and in practices translates into actions seeking to affect educational attainment, occupational status and income inequality. The notion of 'avoidability' is central to this approach and conditions the notion of justice/injustice.

The social egalitarian notion of justice, that is dominant in the social determination of health approach of the LA SM-CH recognises health inequalities as unfair as these are produced by an improper and essentially unjust appropriation of means that reproduce and reinforce an unfair social and economic order shaped by power asymmetries along the lines of social class, gender and race/ethnicity. Rather than a 'rational agent', a 'historical subject' shaped by social relations and within concrete societal arrangement is recognised (Hernández, 2011, p. 182). This same subject is further recognised as a political subject capable of adopting emancipatory praxis instead of passively waiting for state or philanthropic interventions.

Another important distinctive and unifying element of LA SM-CH and ultimately also of the social determination of health approach is that it recognises that 'the science of epidemiology, like "any other symbolic operation […] is a transformed, subordinate, transfigured and sometimes unrecognizable expression of the power relations of a society"' (Breilh, 2008, p. 745). LA SM-CH proposals for transformations on epistemological level have therefore explicitly challenged the epistemological foundations of dominant epidemiological and public health research. In this regard, Naomar Almeida-Filho has produced some of the most refined epistemological and historical analysis about health and epidemiological reasoning, unveiling the limitations implicit in the notions of causality and validity adopted in dominant epidemiological and public health research (Almeida-Filho, 1989, 2000) and proposing an alternative general theory of health (Almeida-Filho, 2001). Ricardo Ayres, Luis David Castiel and Jaime Breilh amongst others proposed an extensive critique of the notion of 'risk' (Ayres, 1997; Breilh, 2003; Castiel, 1999, 2010) and the risk-factor logic that fragments the understanding of social processes and has been emphasised also in the critique of the CSDH SDH approach. This critique has driven extensive work on the concept of 'vulnerability', particularly in the field of HIV/Aids and generally linked to human rights frameworks, radically questioning the traditional epidemiological risk-factor logic that mechanically transformed abstract epidemiological research categories with elevated risk for certain diseases into social identities and ultimately, into target groups (Ayres, 1997; Paiva, Ayres, & Buchalla, 2012). Thereby heterogeneous groups of individuals were reduced to 'risk groups', that undoubtedly influenced highly stigmatising and mostly ineffective prevention campaigns and, as in the case of the HIV/Aids epidemic, isolation measures, for example, directed at men who have sex with men. This critique has not exclusively been formulated by researchers and activists linked to LA SM-CH, but has undoubtedly taken new stances in Latin America, for example, by situating the critique in more structural revisions of the epistemological foundations of modern epidemiology and by incorporating a critique of the notion of 'risky behavior', that is recognised as a mean to depolitize and individualise disease occurrence and distribution, emphasising the need to rather study vulnerability and, this is particularly evident in the 'social determination of the health-disease-care process' approach, on processes of

vulnerabilization, looking into the complex configuration of processes that turn certain social groups and individuals more vulnerable to certain conditions.

The writings of Juan Samaja (1998) have concerned issues of epistemology, semantics and method, providing important insights on social dialectics and the movement between the collective social order and the individual, which has been relevant for overcoming the notorious difficulty to address 'the social', evident in the dominant health equity agenda and particularly the SDH approach, which has resulted in models that establish links between social factors and average health outcomes, but limit the analysis to individual-level expressions, unidirectional links and essentially external associations between factors. The notion of 'subsumption' proposed by Jaime Breilh is central in this regard, takes up Samaja's work and dialogues with the eco-social approach and particularly the notion of 'embodiment' proposed by Nancy Krieger (2001b). Originally applied by Karl Marx to explain the internal and external subjugations operating in the labour process under capitalism, Breilh, following Bolívar Echeverría, incorporates the notion of 'subsumption' to substantiate the idea of social determination. He differentiates

> formal subsumption of the capitalist mode that changes the conditions of property and production/consumption and affects, externally, the relationships between the system of consumption needs and the system of production capacities; and secondly, the real subsumption, or "substantial" subsumption, in which the social internalization of this mode disrupts, from within, the dialectics between needs and capacities. (Breilh, 2011b, p. 394)

Essentially, it describes how the capitalist materiality marks the general, particular and singular level processes and consequently shapes the social-environmental metabolism, 'modes of life' and finally, on singular level, individual-level biological processes and lifestyles.

Jaime Breilh has proposed an early critique of positivism and causation, which unchained a methodological and conceptual search culminating in the pioneering proposal of the category of 'social determination', the previously discussed notion of 'subsumption' as well as the notion of 'modes of life' as a structured and dynamic dimension of the 'epidemiological profile' (Breilh, 2003), which articulates on a 'particular' level, social class, ethnic/racial and gendered power relations ('triple inequity') in correspondence with the ontological understanding of capitalist societies being structured by processes of exploitation, marginalisation and domination, systematically privileging upper class, white, European and male subjects and collectivities (Breilh, 1996). The 'Social determination of the health-care-disease process' approach as proposed by Jaime Breilh accordingly synthesises and expresses the cumulative and yet dynamic interplay between historically, spatially and socially shaped processes of exposure/imposition, susceptibility and resistance.

These ontological and epistemological considerations translate into praxiological imperatives that have shaped the SM-CH praxis as expressed in government experiences (Hernández, Forero, & Torres, 2005; Laurell, 2003), curricular reforms, action-research proposals (Breilh et al., 2005; Soliz, 2014) and constitutional reforms amongst others. The notion of 'praxis' as the articulation between theory and political practice has been central in this regard. In this sense, Latin American SM-CH, influenced by Italian Marxist philosopher Antonio Gramsci, understands theory as contributing to efforts tending towards social change, but at the same time nourished by these efforts. Consequently, research activities of SM-CH practitioners are often developed together with social and political movements, trade unions, community organisations and explicitly support their struggles in correspondence to the ontological understanding of health and health inequities – implying a break with conventional postures of scientific 'neutrality' (Tajer, 2003) and rather considering that 'the generation and transmission of knowledge is a tool for change', as Deborah Tajer puts it (2003, p. 2024).

LA SM-CH certainly finds inspiration in several sources, particularly Marxist critical thought and authors like Bourdieu and Foucault. Its main driving force, however, is a continued reflection on Latin American social, cultural and political reality, including the subaltern knowledge of exploited and oppressed social groups. If dependency theory (Cardoso & Faletto, 1979; Santos, 1979),

liberation theology (Boff, 1987; Gutiérrez, 1975), decolonial theory (Castro-Gómez & Grosfoguel, 2007; Escobar, 2007; Grosfoguel, 2010; Lander, 2005) and participatory action research (Fals-Borda, 1987) can be said to have been the most original contributions of Latin American critical thought in the twentieth century (Bialakowsky, 2012), the LA SM-CH emerges as heir to this tradition (Waitzkin, Iriart, Estrada, & Lamadrid, 2001) and makes major contributions to the field, which can and should no longer be ignored or undervalued. This said, it is important to note that LA SM-CH and its 'social determination of health' approach are, without a doubt, result of transcultural dialogue, within the global South but also with the global North. Apart from its clear dialogue with early European Social Medicine, including works of Virchow and Engels, many representatives of the LA SM-CH pursued postgraduate studies in the global North and in other Latin American countries, which definitely shaped the approaches and the references of LA SM-CH.

Conclusions

In an effort to challenge the apparent consensus for equity in health, this essay offered an overview of the debates shaping the global health equity agenda and compared and contrasted two of the most influential approaches: the WHO SDH approach, strongly influenced by European Social Medicine, and the LA SM-CH 'social determination of the health-disease-care process' approach, hitherto largely invisibilized. Apart from external economic, social and political pressures that have defined the scope and relative dominance of the agenda in relation to agendas placing emphasis on narrowly defined, technology-based interventions, the global health equity agenda is shaped by internal mediations that have defined the way inequities in health are understood, conceptualised and proposed to be transformed. In this regard, and although the approaches ascribing to the health equity agenda are rather heterogenic, we argued that there is a dominant agenda with specific ontological, epistemological and praxiological features, which in recent years has been driven by the WHO SDH approach. The apparent consensus for health equity, which has accompanied the consolidation of the dominant health equity agenda and was reinforced by a systematic invisibilization of alternative approaches and dissent voices, for example in the final report of the CSDH (2007), which contains none but one reference to LA SM-CH, has accordingly consolidated a false universality that annihilates historical trajectories and dilutes the debate.

In the context of the historical and recurrent retreats we discussed for example in relation to the shift from primary health care to selective primary health care but also from universal health systems to universal health coverage, this differentiation seems more necessary than ever as it allows to reveal the often implicit ethical and political proposals and in that way qualifies the debate. While Irwin and Scali (2005, p. 25) seem to welcome the 'relatively more consensual climate' in the international health and development field, moving beyond some of the 'ideologically charged' polarizations of the 1990s, we insist on the need to evince differences and conflicts and are opposed to false consensus backed by discursive adaptations as this seems to weaken the health equity agenda – both the dominant and subalternalized agendas. In order to avoid a 'light' SDH approach substituting the already rather timid WHO SDH approach in the dominant global health equity agenda, its principles and ethical-political foundations need to be clarified in order to avoid an apparently subtle and firstly merely discursive betrayal of its principles. In this regard it seems necessary to question the strong believe in win-win solutions invoked by the dominant health equity agenda and ask whether the gap can truly be closed in one generation, as the CSDH proclaims, if there is no willingness to accept that those who have historically won will have to lose, even if this translates into regression and currency devaluation, which are presently framed as negative and unacceptable scenarios – not to mention a true transformation of social class, ethnic/racial and gendered power relations, the choice for degrowth, non-capitalist economies and what has been referred to as the 'alternatives to (capitalist) development' (Escobar, 2011).

As outlined above, it is necessary and high time to seriously engage with hitherto invisibilized approaches and research traditions as this will broaden and at the same time specify the debate,

facilitating the recognition of contextually relevant proposals towards a systematic reduction of health inequities, the appraisal of processes that shape concrete social realities, history and territory and – rather than the result of a linear association between social factors and individual-level biology – understand the processes that shape differences in health, define the quality of death and suffering and recognise the health-disease-care process as an integral part and expression of social processes and the configuration of power in specific territories.

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