Health differentials associated with social inequality: description, explanation and strategy

Usage

The focus of this chapter is on the different uses of 'social determinants' and 'social determination' in describing, explaining and responding to the health differentials associated with social inequality.

Background

The level of health that a population can achieve is a function of their exposure to risk, their access to resources, and the distribution of those risks and resources.

Reducing general risk exposure and increasing aggregate resources depend on research (resources and priorities), economics (accumulation and investment of capital) and governance (in whose interests). When the level of ill health in a population is understood as being due to population wide exposures and general limits on aggregate resources for health, the political challenge is generally cast in terms of economics and governance (and research priorities).

Health differentials associated with social inequality are an afront to values of solidarity and equity and have long contributed to controversy and conflict. They have been a particular focus of concern within public health. Where the possibilities of good health are exhibited in the lives of the more advantaged strata the levels of stoicism among the disadvantaged are reduced and the frustrations of the public health project are more intense.

There have been inequalities in health status associated with social inequalities for as long as there have been social hierarchies with differential exposures to risk and access to resources. Differential exposure to risk and access to resources have contributed to political tensions and conflicts in different societies for millennia, although not necessarily expressed in terms of health grievances.

The systematic study of social inequalities in health status moved forward during the industrial revolution in Britain and Europe and later in the US; presumably because their health inequalities were so extreme during these transformations. See for example Chadwick (Golding 2006) and Engels (1969[1845]) in England, Ramazzini (Riva et al. 2018) in Italy, Villermé (Anonymous 1850) in France, and Virchow (2006[1848]) in Germany.

The explanations of these health inequalities varied amongst these authors, ranging from Chadwick who believed that poor people needed to be threatened with the workhouse to make them work harder, to Engels and Virchow who highlighted exploitation and oppression across unequal power relations (early capitalism in Manchester, feudalism in Upper Silesia).

These different explanations lead to different policy responses, from the brutalities of poor law reform in England to Virchow's call for revolution in Germany and Engels collaboration with Marx in the Communist Manifesto. Engels was in no doubt that the health inequalities which he described in Manchester were largely attributable to the oppressions and exploitations of capitalism.

In the present period, financialised transnational capitalism has undoubtedly contributed to widening economic inequality globally, particularly since the rise of neoliberalism in the late 1970s. Clearly there has been a mortality cost arising from such widening inequality.

Nevertheless, in most countries there has been continuing improvement in life expectancy, notwithstanding widening inequality. This improvement presumably reflects the impact of developments in science and technology on living conditions and on health care. The US is an

outstanding exception to this trend with an ongoing deterioration in life expectancy in recent years; apparently related to the impact of deindustrialisation and deeply embedded racism.

The mortality experience of East Germany from before and after reunification in 1990 (Vogt 2013) underlines the need for some caution in generalising about the role of capitalism *per se*. A different pattern has been documented in relation to the transitions from last years of the USSR, to the early years of 'shock therapy' and the subsequent improvements following recovery from 'shock therapy' (Shkolnikov, McKee, and Leon 2001; Shkolnikov et al. 1998; Zhang 2015).

Third World leaders (Allende, Fanon, Nehru, Mao, Castro, Mandela) have coupled colonialism and imperialism to the indictment of capitalism in relation to health inequalities. However, the debates around the health inequalities associated with colonialism (including the ongoing dynamics of colonialism after political independence) and imperialism tend to run separately from the debates around health inequalities in the metropolis.

With decolonisation in the mid-20th century and the universal franchise, political acceptability of explicit 'victim blaming' waned and the mainstream political responses to social inequalities in health came to focus on policy reform, from tokenistic to substantive. At the more activist end these policy responses have included environmental and labour laws, social security, food subsidies, housing reforms, and various welfare programs. More conservative responses have generally centred on waiting for the promised benefits from economic growth to 'trickle down' or palliating distress with charity.

Beyond policy reform is revolution. One of the most dramatic improvements in people's health in the 20th century was a consequence of the Chinese revolution (Sidel 1982). While health inequality was not the main driver of this revolution it was definitely a factor. Likewise, the Cuban revolution was a response to broad suffering, and health was a factor. As with the Chinese experience the Cubans have achieved dramatic gains in health (and health equity) notwithstanding the US subversions and blockade (Lobe 2001).

Meanwhile public health researchers have been teasing out the various pathways through which health differentials are driven by social inequality. These range from differential exposures to material hazards and barriers to accessing basic material resources and services, to various bio-psycho-social explanations including relative powerlessness, alienation, lack of social capital, and lack of control and autonomy at work. Other lines of research point to biological mediators of these psycho-social stressors.

Commission on Social determinants of health

In the last two decades much of the research and policy dialogue around health differentials associated with social inequality has been conducted with reference to 'the social determinants of health'.

The phrase, 'the social determinants of health', came into widespread use in the early years of the 21st century, due in large part to the work of the WHO Commission on the Social Determinants of Health and its 2008 report '*Closing the gap in a generation: health equity through action on the social determinants of health'*. The Commission was financially supported funded by the UK, Canada, Sweden and a number of private philanthropies; it was chaired by the British epidemiologist, Michael Marmot.

Marmot had been engaged, with many collaborators, in broad ranging studies of social differentials in health over many years. The abstract from a 1997 paper (Marmot and Davey-Smith 1997) is worth quoting in full:

> *The first Whitehall Study of British civil servants demonstrated an inverse gradient in mortality. The lower the grade the higher was the mortality risk. This higher mortality risk applies to most*

> *but not all causes of death. The Whitehall II Study, set up to investigate causes of this social gradient shows similarly marked gradients in morbidity. A review of potential causes of the gradient suggests that it is due neither to health selection nor simply to differences in lifestyle, but that relative deprivation—a psychosocial concept—and the accumulation of socially-patterned exposures over the life course, must be important. Whitehall II suggests that the operation of these factors is to be found in the specific circumstances under which people grow, live and work.*

In 1998 WHO Europe published an edited collection (Wilkinson and Marmot 1998) exploring the social gradient and the roles of stress, early life, social exclusion, work, unemployment, social support, addiction, food, and transport in shaping population health.

While Marmot has played an important role in clarifying the causes of the social gradient in health outcomes and a critical role in establishing the term 'social determinants' to describe these causes, he was not the first researcher to draw attention to these relationships. Marmot's work forms a link in a long chain of epidemiological research directed to describing, explaining, and responding to the avoidable health burdens of social inequality.

Much of this work has centred on England; see for example, Black and Townsend (1982), McKeown (1979), and Szreter (2004). Among North American authors Berkman (1984), McKinlay (1993), Lynch (1997) stand out. Hamilton (1943) and Karasek (1990) are legends in occupational health.

The WHO Commission on the Social Determinants of Health, set up in 2005 and reporting in 2008, brought together a large body of evidence around early life, urban settings, employment and work, social protection, and health care. The Commission structured its recommendations around 'Power, money and resources': health equity in all policies, fair financing, market responsibility, gender equity, inclusion and voice, and global governance. The Commission's process was highly consultative and engaged a very wide range of countries, organisations, and stakeholder groups which has contributed greatly to the widespread use of the term. The reports of the Globalisation Knowledge Network (Labonté et al. 2007) and the Civil Society Consultation (Civil Society 2007) are particularly useful.

One response to the increased focus on social determinants has been a range of variations on the 'determinants' theme: political determinants (Kittelsen, Fukuda-Parr, and Storeng 2019; Ottersen et al. 2014), sociopolitical determinants (De Vos and Van der Stuyft 2015), and commercial determinants (Kickbusch, Allen, and Franz 2016).

In 2011 the World Conference on Social Determinants and Health was held in Rio de Janeiro, cosponsored by WHO and by Brazil. The Conference adopted the Rio Declaration (World Conference on the Social Determinants of Health 2011) which sought to commit WHO's member states to implement individually and collectively the policy directions recommended by the Commission. The Rio Declaration was endorsed by the WHA in May 2012 in WHA65.8.

The impact of the Commission's recommendations on WHO's programs has been limited. This is in large part a consequence of the refusal of the donors to contribute to the implementation of the recommendations of the Commission or the commitments in WHA65.8. WHO has a small revenue stream which is not tied to particular programs by donors ('assessed contributions', now around 12% if WHO's budget). However, this revenue stream is entirely committed to supporting the basic organisational infrastructure of WHO (which donors also refuse to support).

It is also the case that real action on the social determinants of health (the conditions in which we grow, learn, work, play and slow down) depends on country level decisions rather WHO programs at the global or regional levels.

WHA65.8 provides for the WHO Secretariat to provide advice to countries ('upon request') but the scope of such advice is sharply circumscribed by the politics of donor funding and the threat of a

donor drought. It is self-evident that economic inequality is deepening globally, as a consequence of the (neo)liberalisation and the financialisation of the global economy. However, if the WHO Secretariat were to stray into this territory, notwithstanding its impact on widening health inequalities, the wrath of the donors, led by the USA and the Gates Foundation would be severe.

The G7 are already driving the transfer of global health functions out of the World Health Assembly through 'public private multistakeholder partnerships' (like Covax and the ACT-Accelerator). If countries of the Global South were to push the Secretariat to acknowledge the health consequences of the neoliberal ascendance it is likely that WHO funding would suffer and the transfer of global health to multistakeholder partnerships would accelerate.

The role of neoliberalism in deepening health inequalities is not a secret. Two powerful statements were developed by civil society forces at the Rio Conference, one of which was characterised as a statement by Public Interest Civil Society Organisations and Social Movements (2011) and the other as a statement by Civil Society Movements (2011). The PICSO&SM statement declared that:

> *sustainable development is in crisis with neoliberalism, consumerism individualism over-riding the values of community and international solidarity.*

The CSM statement included:

> *The cause of the inequalities within and between nations is the capitalist economy in its neoliberal form, infused with an exclusively speculative desire for unlimited profit. Capitalism based on the domination of the few over the many and the plundering of nature is the cause of the immense financial, energy, food and ethical crises that we face today. Likewise, it is this capitalist system that has led to the precariousness of work, the loss of labor rights, the destruction of solidarity among workers, and has pushed millions of people into the informal economy and profoundly increased child labor.*

However, the CSM statement went beyond denouncing neoliberalism. It also issued a sharp critique of the concept of social determinants itself.

> *It is time to openly discuss that which we have repeatedly avoided. The social determination of health is much more than a collection of fragmented and isolated "determinants" that, from a reductionist viewpoint, are associated with classic risk factors and individual lifestyles. We must not allow the concept of social determinants of health to become banal, co-opted or reduced merely to smoking, sedentary behaviour and poor nutrition, when what we need is to recognize that behind those symptoms and effects lies a social construction based on the logic of a globalized hegemonic culture whose ultimate goal is the commercialization of life itself.*

Determinants versus determination

The rise of the 'social determinants' paradigm has contributed to a clearer recognition of how people's health is shaped by the conditions in which they learn, work, play, and grow old. It has also contributed to increasing caution regarding individualist accounts of health inequalities and behaviourally focused approaches to policy and practice.

However, it has also been criticised as reductionist and state-centric by the Latin American school of Social Medicine and Collective Health

The social determinants approach emerged out of a particular approach to epidemiology which has been prominent in the UK, Europe and North America in recent decades. However, during this period a different approach was emerging in Latin America, characterised by the use of 'social determination' rather than determinants and 'collective health' rather than public health.

The differences between social determinants and social determination are not simple semantic differences or expressions of parochial competition. Rather they involve profound philosophical and political differences in their approach to health development and therefore epidemiology.

Latin American Social Medicine and Collective Health is a project with roots in many countries in Latin America, in many organisations (ALAMES, ABRASCO, CEBES, and others), and with many contributors to its articulation (Vasquez, Perez-Brumer, and Parker 2019). The close links between the Latin American social medicine and collective health tradition and the revolutionary movements of Latin America have also shaped the development of the social determination paradigm.

The following account draws heavily on the writings of Jaime Breilh including his recent book on critical epidemiology (Breilh 2021). Also useful is the overview of Breilh's thinking by Harvey and colleagues (Harvey, Piñones-Rivera, and Holmes 2022). The contribution of authors from North America who have sought to share the insights of Latin American thinking across the Anglosphere, including Howard Waitzkin (2001) in the US and Jerry Spiegel (2015) in Canada is also to be appreciated.

The following account of the social determination paradigm is structured under six separate headings but these different headings are just different facets of the same complex model; exploring one heading leads directly into each of the others.

Factors versus processes

Much of British and North American epidemiology is focused on abstracting measurable indicators from the more complex organic systems of human biology, environments, and institutions. As the organic complexities recede into the background the indicators turn into more ambiguous *factors*; factors which can be measured; factors which can predict changes in other factors; factors which can be changed through policy.

The social determinants of health are factors which have been shown empirically to affect population health: access to education, healthy urban settings, safe work, social protection, and access to health care. Recognising these factors as social determinants of health articulates smoothly into policy recommendations addressing such factors with a view to promoting health equity.

In the report of the Commission the causes of the social determinants are analysed in terms of policy coherence, fair financing, market responsibility, gender equity, political empowerment and good governance. The consequent policy recommendations are largely directed at governments which is appropriate given that WHO is an intergovernmental organisation.

The Latin American shift to *social determination* emphasises that the creation of population health (and disease burden) is an active agentic process ("we are creating better health" / "health disadvantage is being actively generated"). Social determination is a political process because changing the factors which shape population health is politically contentious and involves political engagement (Spiegel, Breilh, and Yassi 2015).

The elements of agency and contention are obscured in the determinants discourse; are highlighted with the shift to determination.

Linear causality versus the movement of multi-level systems

British and North American epidemiology pursues causality; in its most simple form, as a singular direct causal relationship between measurable factors. Complex causality is recognised but models of such are generally built up around networks of linear causal relations.

Breilh complicates this by insisting that causality operates differently at different levels of scale. He describes these levels as 'styles of living' (the individual level), 'modes of living' (generally associated with the circumstances and cultures of particular identities (class, gender, ethnicity, in particular), and 'general processes' (as in the political economy of capitalism). Breilh recognises a degree of autonomy at each level and a degree of mutual influence between levels. He uses the term

'movement' to describe how causal relationships within and across these levels shapes the evolution of the 'system'.

> *It is important to consider here that when we criticise empiricist causal factor logic, we are not implying that causal relations and factor incidence do not exist. What we mean is that these factors are not the exclusive nor the decisive elements of health determination; their causal incidence is defined, limited and moderated by the conditioning force of collective modes of living and general processes.* (Breilh 2021, p136).

Breilh uses the term 'subsumption' to describe the interrelations of these different levels: "… subsumption involves the conditioning of a less complex movement by a more complex one." (Breilh 2021, p110)

> *Subsumption … explains the inherent determining connection of processes pertaining to different domains of complexity of social reproduction, where the more intricate subsystem imposes its conditions on the movement of the least complex. The less complex individual biopsychological movement in people develops with its own psychological, physiological, and genetic natural reproduction rules, but their complete operation corresponds with and is influenced by the conditions of social reproduction.* (Breilh 2021, , p108)

The insistence on causality operating at multiple levels, including forces which cannot be reduced to linear causality, is critical to the social determination paradigm. It is why the Latin American school can affirm the role of neoliberalism in deepening inequality while British and North American epidemiology tends to avoid it.

Ethics of engagement

British and North American epidemiology is variously driven by curiosity, ambition and concern. However, even when motivated by concern there is an over-riding value of objectivity as critical to integrity. This contradiction between concern and objectivity is handled differently in the Latin American school where the concept of praxis, which integrates political commitment and knowledge production, is valued.

Breilh describes the social determinants paradigm as being directed to the development of policies and practices for 'redistributive governance'. He contrasts this with the concept of praxis in social determination which he explains is practice linked to the strategic interests and empowerment of subjugated groups (class, gender, ethnicity); it is a struggle for radical transformation of inequitable social relations; unhealthy modes of living and alienating cultural patterns. (Breilh 2021, p117)

This commitment to empowerment and transformation demands a different approach to interdisciplinary relations (for example, bridging epidemiology and political economy); a different attitude to the aspirations of subjugated populations (including how they conceive their health); and a different set of research priorities (what do we need to know to change society).

It is worth emphasising here the many instances of close engagement of public health practitioners in the revolutionary movements of Latin America. The sense of being part of a wider struggle for justice is much more recent in Latin American social medicine/collective health than it is in the orthodox epidemiology of Britain, Europe and North America.

Truth and solidarity

Fundamental to the Latin American school is the Foucauldian knowledge power critique; power relations are embedded in the way knowledge is generated, expressed, accessed and utilised. The claim that hegemonic knowledges reflect 'the truth' is a key manifestation (and defence) of knowledge power.

The commitment to empowerment of the subjugated and transformation of the disempowering system has helped to shape the epidemiology of social determination. The concept of praxis calls for a rethinking of disciplinary knowledge as a singular truth, pointing instead to the need for a transdisciplinary approach to knowledge and practice. The recognition of knowledge power calls for a rethinking of (Western) scientific knowledge as a singular truth if the aspirations, traditions and lived experience of different peoples are to be valued.

The truths of scientific disciplines and of Western science itself must be recognised as partial and contingent if the different truths of different cultures are to be respected. The disciplines of science need to be integrated with the building of new stories and new languages through the struggle for deeper communication and solidarity in the course of collaboration.

The concept of interculturality which is central to the Latin American school is a response to the authority of Indigenous traditions and the need for epidemiology to listen and recognise that authority. Breihl acknowledges how the Indigenous movements of Central and South America contributed to the development of his thinking and the enrichment of social medicine and collective health.

A key instance of interculturality is the widespread adoption, across the collective health movement, of the value of living well (buen viivir). Living well gives flesh to the idea that health is more than simply the absence of disease. Recognition of buen vivir decentres the metrics of orthodox epidemiology and points to the need to work with the different meanings of 'health' which emerge in different communities; to co-produce rather than simply declare the purposes and practices of collective health.

While Breilh does not cite de Saussure, the influence of the latter is clear. Roy Harris, the translator and interpreter of de Saussure explains:

> *Words are not vocal labels which have come to be attached to things and qualities already given in advance by Nature, or to ideas already grasped independently by the human mind. On the contrary languages themselves, collective products of social interaction supply the essential conceptual frameworks for men's* [sic] *analysis of reality and, simultaneously, the verbal equipment for their description of it. The concepts we use are creations of the language we speak.* (Saussure 2013[1916] , p.xiv)

Another instance of interculturality is the framing of ecology and environment in terms of our relationship with Pachamamma (Mother Earth). See for example Humphreys (2017) who describes how legal scholars in Ecuador and Bolivia are working to affirm the rights of Pachamama and to support the emergence of a jurisprudence of the earth.

Measurable factors versus under-the-surface forces and dynamics

Breilh is critical of what he calls 'tip of the iceberg' thinking which "resides in substituting the explanation of a complex multidimensional movement with mere description and prediction of partial variations and correlations" (Breilh 2021, p88). Instead, he insists, "The scope of epidemiological observation … must encompass the underlying determinant movements that generate the empirically observable elements" (p 101).

By way of illustration, he cites climate change as the tip of the iceberg of the environmental degradation of late capitalism (p68). Concepts such as neoliberalism and financialisation do not lend themselves to measurement and correlation but are critical objects for any transformation of contemporary transnational capitalism.

State-centric 'public health' versus 'collective health'

A final distinction between determinants and determination concerns the relationship of public health to government.

In the social determinants tradition there is a focus on public policy as the main avenue through which the insights of epidemiology might lead to improved population health, including institutional reforms in the different sectors of social policy: housing, education, welfare, occupational safety, environmental regulation, health care, etc.

The insight which underpins the use of 'collective health' instead of 'public health' is that while many public health initiatives may be enacted through government, population health is created in families, communities, and in the various subcultures of the wider polity. Where government does act, it is commonly a reflection of popular demand and political struggle, not just the rational implementation of enlightened policy based on the findings of objective epidemiological research.

A reflection on the WHO Commission on the Social Determinants of Health

The report of the Commission was a watershed moment in public health globally. Birn (2009) acknowledges that: a) it brought greater legitimacy to the societal determinants of health field and to calls for better measurement and monitoring of health inequity; b) it discussed the global dimensions of social inequalities in health; and c) it identified the role of public health systems as an important determinant of health. Birn follows this acknowledgement with an extended critique of the Commission's report, drawing on history and contemporary research. (She also comments that the Commission's report also fails to refer to Krieger (2000), Navarro (2001) or Waitzkin (2001) all of whom have made important contributions to understanding and responding to health inequality.

The Commission declared that injustice is killing people on a grand scale but as Navarro (2009) pointed out it is the proponents and beneficiaries of global injustice who are killing people. Michael Marmot (2012) has called for a global movement for health equity but the Commission's report pays no attention to the Latin American school of social medicine and collective health which has pioneered an approach to epidemiology which clearly envisages public health people working with their communities to build exactly such a movement (Harvey, Piñones-Rivera, and Holmes 2022).

Implications for public health policy and practice

The foregoing explication of the contradictions between social determinants (and British / North American epidemiology) and social determination (and Latin American social medicine and collective health) should not be taken as discounting the huge advances which have been achieved by epidemiology generally (knowledge and methods) including British, European and North American epidemiology. Progressive public health (collective health) must deploy all the resources at its disposal.

In reflecting on the implications for progressive public health of the agreements and contradictions discussed in this chapter it is useful to reflect on the sequence of high profile statements on health development over the last five decades.

The Alma-Ata Declaration on Primary Health Care (1978) offers a vision of primary health care practitioners working with their communities to provide health care and to identify and address the social conditions which shape their health. The Declaration was inspired by a range of different stories of primary health care (Newell 1975), including: individuals projecting medical leadership and working with their communities in health care and beyond; instances of primary health care emerging in the context of resistance to oppression; and the examples of China and Cuba in developing forms of primary health care which are structured around working with communities in health development.

The Declaration explicitly touched upon global economic reform with its reference to the New International Economic Order of 1974 (Cox 1979; UNGA 1974). The NIEO called for reform of global trade and finance to provide developing countries with certain economic privileges to facilitate their

economic development. These included a level of industry protection and the right to nationalise foreign corporations.

The optimism of Alma-Ata and the NIEO was quenched with the debt crisis from the 1980s and the progressive emergence of the Washington Consensus and its transformation into neoliberalism.

The Alma-Ata Declaration continues to inspire enthusiasm across the Global South and in streams of public health. However, the dominant forces in global health policy have waged a long campaign to replace PHC with UHC and to reduce PHC to 'primary care'.

The principles of social determination are expressed clearly in the PHC tradition.

Many developing countries were caught in the 1980s debt trap when global interest rates climbed to new highs (driven in large part by Federal Reserve Board of the USA). Countries who were forced to seek bailouts from the IMF were required to implement austerity and liberalise their economies through 'structural adjustment'. The impacts on food, jobs, housing, farming, and health care were devastating.

Structural adjustment was not conceived as a 'health policy' but in its 1993 World Development Report the World Bank set out to demonstrate how structural adjustment could be implemented in a way that would contribute to population health improvement. For health care the Bank proposed a stratified, marketised model of care with public funding reduced to support a minimalist safety net but disbursed as a subsidy within a competitive health insurance market. For public health the Bank introduced a new metric, the disability adjusted life year (DALY), and a new prioritising tool based on the 'burden of disease'. The Bank produced cost effectiveness estimates (dollars per DALY averted) for a range of public health interventions and urged priority to those interventions with a high cost effectiveness. The Bank calculated that infrastructure interventions such as water supply and sanitation were not cost effective. (They achieved this by assigning the total cost of such interventions to the health sector rather than recognising the many intersectoral benefits of urban infrastructure.)

'Investing in Health' did not address health inequalities per se and normalised a global economic regime which nourished economic inequality. The recommendations of Investing in Health were implemented in many developing countries under the title of 'health sector reform'. Much of the passion of Latin American social medicine and collective health emerged from the struggle against health sector reform.

The slogan 'investing in health' had a reprise in the 2001 report of the WHO Commission on Macroeconomics and Health (2001). The need for this report emerged from the AIDS crisis of the late 1990s following the development of retroviral therapies which poor people and poor countries could not afford because of high prices (protected through the provisions of the TRIPS Agreement).

The Commission repeated much of the logic of the 1993 report and argued for a 'targeting of a relatively small set of diseases and conditions' (P42). However, it placed its main emphasis on the need to mobilise donor funding from the rich countries to support the procurement and distribution of medicines and vaccines for poor countries. Jeffrey Sachs, the chairperson of the Commission, advocated energetically for what became the Millennium Development Goals. Sachs was fully aware that 'globalisation is on trial' (p15) and saw the mobilisation of billions of dollars including from the World Bank and the Gates Foundation, as necessary to restore the legitimacy of neoliberal globalisation in the eyes of the Global South.

The achievements of the Commission on the Social Determinants of Health in 2008 were mixed. The Commission named health inequalities as unjust and it recognised, albeit in very general terms, that the prevailing economic regime was driving such inequalities. (These relationships were explicated more clearly in the report of the Commission's Knowledge Network on Globalisation (2007).) However, as denounced in the civil society statements at the 2011 World Conference (see above),

the Commission failed to fully indict neoliberalism or to demonstrate how it fitted into the causalities which informed the Commission's findings.

In terms of addressing health inequalities, there is a stark contrast between Alma-Ata and the Commission on SDH, on one hand, and Investing in Health and the Macroeconomic Commission, on the other. There was nothing in either Investing in Health or the Macroeconomic Commission Report which saw deep global inequality as problematic. The priorities for them were restoring legitimacy of structural adjustment in 1993 and of the TRIPS Agreement in 2001. In contrast, both Alma-Ata and the SDH Commission were clearly directed to addressing the disease burden of social inequality.

However, a major difference between Alma-Ata and the SDH Commission lies in the audiences they were addressing. The messages of the SDH Commission were largely addressed to governments whereas the messages of Alma-Ata were also directed to primary health care practitioners, seeking to inspire them to explore different ways of practising and through them to inspire their communities. These differences illustrate the Latin American critique of the Social Determinants Commission as being statist in ascribing agency to governments but not fully recognising the agency of civil society. This concern to recognise the agency of ordinary people in their various collectivities lay behind the preference for the term 'collective health', discounting what Breihl calls 'functional public health'. It illustrates the criticism of social determinants as factors rather than highlighting the process of determination and the agency of people in struggling to achieve better living conditions.

The two civil society statements which were declared at the World Conference correctly diagnose neoliberal capitalism as driving health inequalities but assume in their orientation that reforming the global economy required the collective agency of social movements.

In fact, the best statement of the social movement strategy for global health remains the People's Charter for Health , adopted at the first People's Health Assembly in December 2000. The Charter envisages a convergence of social movements across borders and across difference; appreciating that while their local grievances may vary there are common underlying dynamics, in particular the depredations of global capitalism.

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