Indian J Med Res 129, February 2009, pp 117-119

Editorial

Commission on Social Determinants in Health: A piece meal move?

The Universal Declaration of Human rights states that 'Everyone has the right to a standard of living adequate for the health and well-being for him (her) self and his/her family, including food, clothing, housing and medical care and necessary social service. Everyone has the right to education'. Despite this welcome note, the health inequality gap between the poorest low-income countries and the rest has widened over the last 20 years[1].

A whole network of international organizations and actors is engaged in monitoring global trends, global problems, and global crises, based on the assumption that problems must be solved by joint action and with the participation of all. The UN system is a key part of this, and needs to be strengthened and reformed. The same is true of the World Health Organization. Indeed, the launch of the Commission on Social Determinants of Health was designed to make the WHO more active in the social sphere.

In March 2005, the World Health Organization came up with the idea of setting up a Commission, which caters to the social determinants of health. In the opinion of the WHO, the need and demand for clear scientific evidence[2] to inform and support the health policymaking process were the rationale for setting up such a commission. And the field of the social determinants of health is perhaps the most complex and challenging of all. It is concerned with key aspects of people's living and working circumstances and with their lifestyles. It is also concerned with the health implications of economic and social policies as well as with the benefits that investing in health policies can bring.

The central premise of the Commission's work is to achieve and strengthen health equity both within and across the countries which specifies a movement away from the concentration on the immediate causes of disease to levying focus upon the 'causes of the causes' that is the fundamental structure of the social hierarchy and the socially determined conditions these structures create in which people grow, live and age - the social determinants of health[3]. The Commission's mandate was to recommend interventions and policies to improve health and to narrow down the health inequalities through action on the social determinants. It places action to ensure fair health as better health, which makes not just economic sense, but also a matter of right and justice. In the view of the Commission the vast majority of inequalities in health between and within countries are avoidable, and, hence, inequitable. Technological solutions are important but not sufficient to counter this, as yielding sustainable returns require action on the societal causes, which helps in empowering people, communities and countries[3].

The Commission in its effort to assist the world on the social determinant of health has listed certain determinants, which in its opinion are central to tackle health inequalities. The determinants identified are early child development, women and gender, urban setting, employment, health system, measurement and evidence, globalisation, and social exclusion.

The Commission on Social Determinants of Health has nine knowledge networks[3]. This article is based on the review of the final reports of the Knowledge Networks (KN) on Early child development, Globalisation, Employment, Women and gender, Social exclusion, Priority public health condition (scoping paper), Health system knowledge, Urban setting knowledge, Measurement and Evidence based knowledge network and the interim report[3]. The review shows how the different knowledge networks addressed the specified social determinants of health and proposed analytical frameworks and models for action based on certain accepted principles and norms. The Commission's final report[4], which was launched on August 28, 2008, was also reviewed.

The strength of the Commission lies in its ability to bring to light the issue of social determinants of health after the Alma Ata Declaration. With rise in world inequities and the consequent health inequity today in the neoliberal world order, the Commission brings to the

forefront the concern for social justice, important role of World Health Organisation in reducing health inequities[4] and opening a much needed forum for discussions, debates, concerns, criticisms and analyses.

The Commission faces certain limitations. Firstly, the Commission's knowledge networks final reports pose a paradoxical and unclear note on the responsibility of catering to the social determinants of health where different spheres like individual, family, relational, residential, community, national and global, *etc.,* are identified for action but the much needed role of the State in influencing social determinants of health is not given importance. On the other hand, it gives the private sector importance for bringing health equities through corporate social responsibility. Secondly the commission has given models and frameworks for action but it refrains from explaining how the countries facing the challenges of neoliberalism in the present context can move into the models suggested. Therefore, the Commission does not challenge the neoliberal world order but adopts a functionalist approach by proposing work on a few social determinants of health. Here again, the question arises how far the Commission will be able to reduce health inequities through its proposed few social determinants.

The implicit assumption of the Commission is that inaction on social determinants of health is due to lack of knowledge regarding them. This masks the real issue of power relations precluding the national governments not able to take actions on the social determinants. It is also important to know who decides which social determinant is important as the list of social determinants of health is long and each determinant holds its importance depending on the contextual realities. Therefore, the question is how far the stated determinants would reduce health inequity?

It is important to know how the Commission mobilizes different countries to adopt its frameworks on social determinants as each country's contextual realties vary and any force from Commission can become a sign of encroachment on the national policy space which the Commission itself propagates to not to violate. The Commission's knowledge networks fail to address the existence of power relations at each realm of the social structure and its dynamics. An issue that remains largely hidden in these discussions of the social determinants of health is that of social class and its meaning within capitalist society. The literature usually refers to income, social status, or socio-economic positions as primary social determinants of health, which serve to depoliticise much of the discussion about stratification within societies[5].

The final report of the Commission gives an impression that the 'whole world is one family' where the responsibility for improving social determinants of health is placed on all the players in the society whether private sector, public sector, state, government, civil societies, communities or international bodies[4] without realising the unequal power relations exiting in the society. Further, it makes much more emphasis on global to local approach than the historically important intersectoral approach. The vagueness is more evident when the Commission implies to bring universal social protection and health care for all policies [4] for all demonstrating a utopian vision in the glaring unequal world.

The final report admits that growth alone is not a panacea for achieving health equity; distribution is equally important. It also admits that maldistribution of health services need to be addressed and is an important determinant of health. The three important pillars of action according to the report are: (*i*) improve the conditions of life and the circumstances in which people live and work, (*ii*) address the inequitable distribution of structural drivers - power, money and resources- at the global, national and local level and, finally (*iii*) measure the problem, evaluate the actions and address the issue of human resources through which health services can be delivered. However, the final report takes up its model from Solar and Irwin (2007)[3], which ignores the much important determinants like power[6], racism[6], class, honour, discrimination, *etc*. The final report is also criticized for its current model, which fails to make a distinction between the determinants of health and health inequities[7].

To conclude, Professor Sir Micheal Marmot quotes Chile's Pablo Neruda and invites people to: 'rise up with me … against the organization of misery [8] which echoes like a revolutionary move but after reviewing the work of the Commission, it seems much like a piecemeal move without any real challenge to the organization of misery.

K.R. Nayar* & Sonali Sahni Kapoor
Centre of Social Medicine & Community Health
Jawaharlal Nehru University
New Delhi 110 067, India
**For correspondence*:
krnayar@mail.jnu.ac.in

References

1. Nayar KR. Social exclusion, caste & health: A review based on the social determinants framework. *Indian J Med Res* 2007; *126* : 355-63.
2. World Health Organization. Commission on Social determinants of health. Action on the Social Determinants of health: Learning from previous experiences. The background paper prepared for the first meeting of the Commission on Social determinants of health.*WHO*.Geneva.2005. Available from: *http://www.who.int/social_determinants/en/*, accessed on April 2, 2005.
3. World Health Organisation. Commission on Social determinants of health. Achieving Health Equity: from root causes to fair outcomes: Commission on social determinants of health Interim statement.*WHO*.Geneva.2008. Available from: *http://www.who.int/social_determinants/en/*, accessed on November 15, 2007.
4. World Health Organisation.Commission Social Determinants of Health. Closing the gap in a generation: Health equity through action on the social determinants of health. *WHO*. Geneva. 2008. Available from: *http://www.who.int/social_determinants/final_report/en/index.html*, accessed on August 31, 2008.
5. Raphael D. Social Determinant of Health: Present Status, Unanswered Questions, and Future Directions*. Int J of Health Services* 2006; *36* : 651-77.
6. Blakely T. Iconography and Commission on the Social Determinants of health (and health inequity). *J Epidemiol Community Health* 2008; *62* : 1018-20.
7. Kreiger N. Ladders, pyramids and champagne: the iconography of health inequities. *J Epidemiol Community Health* 2008; *62* : 1098-104.
8. Marmot M. *Health in an unequal world*: Great Britain: Royal College of Physicians of London; 2006.