THEMES AND DEBATES

# Making it Politic(al): *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health*

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The anniversary of the publication of *Closing the Gap in a Generation* (*CGG*) offers a moment to reflect on the report's contributions and shortcomings, as well as to consider the political waters ahead. The issuance of *CGG* was not the first time the World Health Organization (WHO) raised the problem of global inequalities in health. Numerous analysts and advocates have compared *CGG* to the 1978 *Declaration of Alma-Ata.*[1] Some see *CGG* as a continuation of Alma-Ata; others malign it for paying insufficient attention to the principles, background documents, and lines of action proposed in the Alma-Ata declaration.[2]

We might understand the two reports as bookends to 30 years of brutal global capitalism, punctuated by the "lost decade" of the 1980s, the end of the Cold War, and, more recently, the implosion of global finance. This period saw the publication of two seminal neoliberal health manifestos–the World Bank's 1993 *World Development Report* and the WHO's 2002 Commission on Macroeconomics and Health report. Both feature the term "investing in health"[3] in their title, conveying "a double meaning—investing [through "cost-effective," narrow, technical interventions] to improve health, economic productivity, and poverty; and investing capital, especially private capital, as a route to private profit in the health sector."[4]

Trailing these reports, the WHO's launching of the Commission on Social Determinants of Health (CSDH) in 2005 under Sir Michael Marmot's leadership provided a ray of hope for the myriad public health researchers, practitioners, and activists who believe that social justice is at the very core of

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[1] WHO, *Declaration of Alma-Ata*, International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 September 1978.

[2] This comparison began even before its publication. See Debabar Banerji, "Serious Crisis in the Practice of International Health by the World Health Organization: The Commission on Social Determinants of Health," *International Journal of Health Services*, 36, no. 4, 2006, 637–50; WHO Commission on Social Determinants of Health, *Civil Society Report, October 2007*, www.who.int (accessed January 24, 2008).

[3] World Bank, *World Development Report 1993: Investing in Health* (New York: Oxford University Press for the World Bank, 1993); WHO, *Macroeconomics and Health: Investing in Health for Economic Development. Report of the Commission on Macroeconomics and Health* (Geneva: WHO, 2002).

[4] Howard Waitzkin, "Report of the WHO Commission on Macroeconomics and Health: A Summary and Critique," *Lancet*, 361, no. 9356, 2003, 523. See also Alison Katz, "The Sachs Report: Investing in Health for Economic Development or Increasing the Size of the Crumbs from the Rich Man's Table? Part I," *International Journal of Health Services*, 34, no. 4, 2004, 751–73; Anne-Emanuelle Birn, Yogan Pillay, and Timothy H. Holtz, *Textbook of International Health: Global Health in a Dynamic World*, 3rd ed. (New York: Oxford University Press, 2009).

public health.[5] Its establishment was the fruition of an uphill struggle to counter the dominant paradigm of health as an instrument and driver of economic growth rather than as an intrinsic human right and value.[6]

**Welcome Contributions**

*CGG* makes three important contributions: a) it brings greater legitimacy to the societal determinants of health field and calls for better measurement and monitoring of health inequity[7]; b) it discusses the global dimensions of social inequalities in health; and c) it identifies the role of public health systems as an important determinant of health.

For the societal determinants of health,[8] the old saw "If you don't ask, you don't know, and if you don't know, you can't act"[9] holds truer than ever. Without knowledge of local, national, and international health and illness patterns, action to reduce inequities is highly limited. Historically, those supporting the argument that social injustice underlies social inequalities in health have generally wielded less power in most settings (and official reports) [10] than those arguing that, for example, personal failings or inadequate economic growth drive inequality.

As such, *CGG*'s foremost contribution is the legitimacy that the WHO has conferred upon the field of societal determinants of health and on the researchers, teachers, practitioners, advocates, and activists who engage with/in this field: "Acknowledging that there is a problem, and ensuring that health inequity is measured—within countries and globally—is a vital platform for action."[11] Most usefully, *CGG* proposes a Health Equity Surveillance Framework, [12] with recommendations on how societal determinants of health should be systematically measured, collected, shared, and analyzed at local, national, and global levels, in order to better inform policy.

This focus on measuring health inequity builds upon existing efforts, such as the Global Equity Gauge Alliance (GEGA), a network of scholars, activists, and policymakers from Latin America, Africa, and Asia active since 1999 in establishing local and national gauges that assess, mobilize around, and monitor equity in health and health care.[13]

GEGA's platform underscores *CGG's* second contribution: its truly global scope. Evidence of inequalities in health, explanations of how societal

[5] Nancy Krieger and Anne-Emanuelle Birn, "A Vision of Social Justice as the Foundation of Public Health: Commemorating 150 Years of the Spirit of 1848," *American Journal of Public Health*, 88, no. 11, 1998, 1603–06; Richard Hofrichter, ed., *Health and Social Justice: Politics, Ideology and Inequity in the Distribution of Disease* (San Francisco, CA: Jossey-Bass, 2003).

[6] Fran Baum, "Cracking the Nut of Health Equity: Top Down and Bottom Up Pressure for Action on the Social Determinants of Health," *Promotion and Education*, 14, no. 2, 2007, 90–95.

[7] Defined as avoidable inequalities in health.

[8] Though the term social determinants of health is widely used, including in *Closing the Gap*, I will employ societal determinants of health to refer to the structural forces that affect health. Strictly speaking, the social determinants of health refer to those factors related to interactions among people and communities, whereas societal determinants emphasize a broader array of historical, political, economic, and other structural influences that are manifest at global, national, community, and household levels. See Barbara Starfield, "Are Social Determinants of Health the Same as Societal Determinants of Health?" *Health Promotion Journal of Australia*, 17, no. 3, 2006, 170–73; and, for an earlier use of the term, Jonathan M. Mann, Sofia Gruskin, Michael A. Grodin, and George J. Annas, eds., *Health and Human Rights? A Reader* (New York: Routledge, 1999).

[9] Nancy Krieger, "The Making of Public Health Data: Paradigms, Politics, and Policy," *Journal of Public Health Policy*, 13, no. 4, 1992, 412.

[10] Surprisingly, *Closing the Gap* fails to cite the work of Nancy Krieger, who has been a modern pioneer of the field of social inequalities in health, theoretically, empirically, and practically. For starters, see Nancy Krieger, ed., *Embodying Inequality: Epidemiologic Perspectives* (Amityville, NY: Baywood Publications, Inc., 2005) and www.hsph.harvard.edu/faculty/nancy-krieger/ Also excluded are the insights of Vicente Navarro and Howard Waitzkin, both cited ahead, regarding the relation of political power to social inequalities in health.

[11] CSDH, *Closing the Gap*, 206.

[12] CSDH, *Closing the Gap*, 182.

[13] Global Equity Gauge Alliance, *The Equity Gauge: Concepts, Principles, and Guidelines. A Guide for Social and Policy Change in Health* (Durban: Global Equity Gauge Alliance and Health Systems Trust, 2003).

factors affect health, and useful examples of addressing these determinants all draw from the experiences of both "developing" or "transitional" and "developed" countries.

To date, the mainstream societal determinants of health literature has concentrated on Europe, North America, and other industrialized settings, where data and funding are more readily available. This bias towards the global North has focused research on inequalities (in income, occupational position, and other factors)[14] thereby downplaying the importance of material conditions—the absolute poverty faced by one-third of the world's population who live on less than two U.S. dollars per day[15] and lack (adequate) access to food, water, shelter, education, medical care, and other human needs. Certainly the perspectives of political economy of health[16] and social medicine[17] also emphasize material circumstances, but they do not necessarily measure the range of factors included in societal determinants approaches. *CGG* covers relative inequality *and* absolute deprivation, understanding that *both* matter in the global North *and* South.

Third, *CGG* recognizes the role of health care systems as a relevant—though not the principal—determinant of health. This factor has been overlooked in recent years by some societal determinants literature.[18] *CGG* appropriately restores the role of universal access to quality health systems, and, especially, primary health care[19] in helping diminish health inequities,[20] particularly in the context of strengthened welfare states. In that sense, *CGG* transcends simplistic and often divisive upstream/downstream dichotomies of determinants of health (viz., that addressing underlying political factors will, for example, automatically resolve intermediary issues, including access to primary care).[21]

**Shortcomings**

As several critics have noted, *CGG* fails to examine why policies that were first advocated in the Alma-Ata declaration–and that are again recommended in *CGG*–have not been enacted,[22] and it ignores the political context of WHO's

[14] For example, Richard Wilkinson and Michael Marmot, eds., *Social Determinants of Health: The Solid Facts*, 2nd ed. (Copenhagen: WHO EURO, 2003); Richard Wilkinson and Kate E. Pickett, "Income Inequality and Population Health: A Review and Explanation of the Evidence," *Social Science and Medicine*, 62, no. 7, 2006, 1768–84.

[15] World Bank, *World Development Indicators 2007* (Washington, D.C.: World Bank, 2007).

[16] Leslie Doyal with Imogen Pennell, *The Political Economy of Health* ( London: Pluto Press, 1979); Imrana Qadeer, Kasturi Sen, and K.R. Nayar, eds., *Public Health and the Poverty of Reforms: The South Asian Predicament* (New Delhi: Sage, 2001).

[17] Saúl Franco, Everardo Nunes, Jaime Breilh, Asa Cristina Laurell, *Debates en Medicina Social* [Debates in Social Medicine] (Quito, Ecuador: Pan American Health Organization and Latin American Association of Social Medicine, 1991); Howard Waitzkin, Celia Iriart, Alfredo Estrada, and Silvia Lamadrid, "Social Medicine Then and Now: Lessons from Latin America," *American Journal of Public Health*, 91, no.10, 2001, 1592–601.

[18] Ichiro Kawachi and Bruce Kennedy, *The Health of Nations: Why Inequality Is Harmful to Your Health* (New York: New Press, 2002); Sandro Galea, ed., *Macrosocial Determinants of Population Health* (New York: Springer, 2007); Michael Marmot and Richard Wilkinson, eds., *Social Determinants of Health* (New York: Oxford University Press, 1999).

[19] Barbara Starfield, Leiyu Shi, and James Macinko, "Contribution of primary care to health systems and health," *Milbank Quarterly*, 83, 2005, 457-502.

[20] Rosana Aquino, Nelson F. de Oliveira, and Mauricio L. Barreto, "Impact of the Family Health Program on Infant Mortality in Brazilian Municipalities," *American Journal of Public Health*, 99, 2009, 87–93.

[21] Nancy Krieger, "Proximal, Distal, and the Politics of Causation: What's Level Got to Do With It?" *American Journal of Public Health*, 98, no. 2, 2008, 221–30.

[22] Diana Obregón, "We are under no illusions": *Closing the gap in a generation*, the report of the WHO Commission on Social Determinants of Health, paper presented at The World Health Organization and the Social Determinants of Health: Assessing theory, policy and practice, Wellcome Trust Centre for the History of Medicine at UCL, London, UK, 26-28 November 2008. This was also forecast by Alec Irwin and Elena Scali, *Action on the Social Determinants of Health: Learning from Previous Experiences. A Background Paper Prepared for the Commission on Social Determinants of Health* (Geneva: WHO, Secretariat of the Commission on Social Determinants of Health, 2005).

financial and organizational problems of recent decades.[23]

**Social Murder, on a grand scale**

Equally troubling is *CGG's* exclusion of the historical debates over the existence, tracking,[24] meaning, and addressing of inequities in health.[25] The weight of history is perhaps greatest on *CGG's* back cover clarion call: "Social injustice is killing people on a grand scale." This is a less impolite formulation of Friedrich Engels's concept of "social murder":

> *If a worker dies no one places the responsibility for his death on society, though some would realise that society has failed to take steps to prevent the victim from dying. But it is murder all the same. I shall now … prove that, every day and every hour, English society commits what the English workers' press rightly denounces as social murder.*[26]

Not only was Engels arguing that social injustice was killing on a grand scale, he identified the perpetrators: the English aristocracy and bourgeoisie.[27] As Vicente Navarro shows, *CGG* eschews these questions of power altogether: "It is not *inequalities* that kill, but *those who benefit from* [and perpetuate] the inequalities that kill."[28] In avoiding historical contextualization, *CGG* misses the chance to trace the lines of accountability for the killing fields and factories of social injustice.

*CGG* undercuts itself by failing to acknowledge the historical debates and struggles that have shaped understandings of the societal determinants of health, and thus the report underplays the significant obstacles in translating its recommendations into reality. The approaches of key 19th century societal determinants thinkers—Louis-René Villermé, Edwin Chadwick, Friedrich Engels—illustrate how overlapping empirical findings regarding the relationship between poverty and mortality yielded divergent interpretive frameworks and political projects.[29]

French surgeon turned social researcher Louis-René Villermé (1782–1863) discovered persistent, systematic differences in mortality by Parisian *arrondissement* (neighborhood), using published data.[30] Unable to find a satisfactory environmental explanation for these patterns (and unwilling to accept a cosmological one), he painstakingly demonstrated that mortality patterns correlated almost perfectly with poverty rates: the poorer the neighborhood, the higher the mortality, in a consistent, stepwise fashion.[31] But as a liberal[32] free

[23] Vicente Navarro, "What We Mean by Social Determinants of Health," *Global Health Promotion*, 16, no. 1, 2009, 5–16.

[24] David Mechanic, "Rediscovering the Social Determinants of Health," *Health Affairs*, 19, no. 3, 2000, 269–76.

[25] Howard Waitzkin, "The Social Origins of Illness: A Neglected History," in *Embodying Inequality: Epidemiologic Perspectives*, ed. Nancy Krieger (Amityville, NY: Baywood Publications, Inc., 2005).

[26] Friedrich Engels, *The Condition of the Working Class in England*, trans. and ed. W. O. Henderson and W. H. Chaloner (1845; Palo Alto, CA: Stanford University Press, 1968). See also: http://dissidentvoice.org/2008/09/engels-and-the-who-report/

[27] Robert Chernomas and Ian Hudson, *Social Murder, and Other Shortcomings of Conservative Economics* (Winnipeg: Arbeiter Ring Publishing, 2007).

[28] Navarro, "What We Mean by Social Determinants of Health," 15.

[29] These issues are covered in detail in a separate piece: Anne-Emanuelle Birn, "Historicising, Politicising, and "Futurising" *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health,* in *The World Health Organization's Commission on the Social Determinants of Health: Critical Perspectives*, edited by Harold Cook, Sanjoy Bhattacharya, Sharon Messenger, and Caroline Overy. Hyderabad, India: Orient Blackswan, forthcoming 2010.

[30] Louis-René Villermé, "Rapport fait par M. Villermé, et lu à l'Académie royale de médicine, au nom de la Commission de statistique, sur une série de tableaux relatifs au mouvement de la population dans les douze arrondissements municipaux de la ville de Paris pendant les cinq années 1817, 1818, 1819, 1820 et 1821," *Archives générales de médecine*, 10, 1826, 216–47.

[31] Ann F. La Berge, *Mission and Method: The Early Nineteenth-Century French Public Health Movement* (Cambridge: Cambridge University Press, 1992); William Coleman, *Death Is a Social Disease: Public Health and Political Economy in Early Industrial France* (Madison, WI: University of Wisconsin Press, 1982); Krieger ,"The Making of Public Health Data."

marketeer, Villermé opposed public policies aimed at social melioration. Instead, he saw poverty—interpreted as immorality (vice, drink, debauchery, idleness, bad habits)—as a personal failing that could be overcome both through individual effort and the further advancement of capitalist industrialization. While Villermé's investigations of social inequalities in health were pathbreaking, even revolutionary, his conclusions were laissez-faire to the extreme, absolving the French bourgeoisie of the need to address misery or inequality either through public health measures or broad social welfare policies.

In Great Britain, the two most prominent figures in the debates over public versus private responsibility for health and welfare were Edwin Chadwick (1800-1890) and Friedrich Engels (1820-1895). Chadwick, a lawyer, utilitarian, and civil servant, was the main author and administrator of the heartless New Poor Law of 1834, which compelled the destitute to enter urban "hellhole" workhouses instead of receiving assistance in their home parishes. Chadwick subsequently embarked upon sanitary reform, fueled by the belief that because illness produced poverty, preventing disease could lower welfare spending. Akin to the contemporary "investing in health" approach, Chadwick was blind to the reverse causal direction—that poverty produces illness. His mammoth 1842 *Report on the Sanitary Condition of the Labouring Population of Great Britain* documented horrendous living conditions, overcrowding in factories and dwellings, and environmental problems of street filth and poor sanitation, as well as pervasive class differences in life expectancy among the gentry, tradesman, and laborers in different locales.

Chadwick's recommendations, directed to enlightened civil servants, businessmen, and legislators, called for drainage and sewage disposal, clean water supplies, and regular refuse collection. Like Villermé, Chadwick believed that the poor were immoral and unclean, but (based upon the miasmatic theory of disease) he held that noxious environmental conditions were a principal cause of disease and poverty. Despite the evidence before him of the dire circumstances of the English working class, Chadwick's narrow interpretation—and willful disregard for accountability for these circumstances—led him to reject improved working and living conditions (beyond environmental measures), higher wages, or even food as remedies for misery and pauperism.

Engels, a German industrialist's son turned political radical, published *The Condition of the Working Class in England* in 1845, synthesizing his own perceptive observations with information from existing studies and reports. Engels's tome was political, incendiary, and paid great attention to the oppression and suffering of working people.[33] As Howard Waitzkin has shown, Engels presciently linked industrial work processes and exposures to musculoskeletal and eye disorders, neurological problems, and lung ailments.[34] Engels reiterated various of Chadwick's findings on inequities in life expectancy and child mortality by occupational class; he also cited an official survey revealing stepwise increases in crude mortality by class at the level of both individual houses and of streets, demonstrating the effect of context.[35]

Chadwick's inquiry and Engels's work yielded the same general patterns as Villermé's: the lower the social class/occupation, the higher the mortality and vice versa. Notwithstanding this similarity of findings on social inequalities in health, Engels's interpretation of the data, his call for action, and his

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[32] Liberal in the eighteenth century political philosophy sense, that is, based on individual liberties and unfettered trade. Not to be confused with the U.S. interpretation of liberal as on the political left or having progressive politics.

[33] Waitzkin, "The Social Origins of Illness."

[34] Howard Waitzkin, "Political Economic Systems and the Health of Populations: Historical Thought and Current Directions," in *Macrosocial Determinants of Population Health*, ed. Sandro Galea (New York: Springer, 2007).

[35] Engels, *The Condition of the Working Class in England*, 121; George Davey Smith, "Down at Heart—The Meaning and Implications of Social Inequalities in Cardiovascular Disease," *Journal of the Royal College of Physicians*, 31, no. 4, 1997, 414–24; Nancy Krieger, "Historical Roots of Social Epidemiology: Socioeconomic Gradients in Health and Contextual Analysis," *International Journal of Epidemiology*, 30, 2001, 899–900.

**Nineteenth Century Health Inequity Paradigms: Laissez-faire, Reform, Revolution**
**Source: Author**

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|---|---|---|
| Villermé | • Poverty and vice cause illness and disease | • Individuals need moral improvement; Society needs laissez-faire industrial development |
| Chadwick | • Filth and immorality cause disease and poverty | • Sanitary reform needed |
| Engels | • Capitalism and class exploitation produce poverty, disease, and death | • Revolution needed |

intended audience were in sharp contrast to those of Villermé and Chadwick. Engels believed that working class mobilization against the capitalist system—as opposed to Villermé's laissez-faire approach and Chadwick's meliorative legislation from above—was necessary to rout exploitation, poverty, and their social and health effects. Soon after Engels articulated his profoundly political framing of the societal determinants of health, he joined Karl Marx in a lifelong collaboration, beginning with their joint authorship of the 1848 *Communist Manifesto*.

This comparison of Villermé, Chadwick, and Engels is a clear reminder that: 1) evidence of the association between poverty and ill health is longstanding; 2) social inequality in health data are interpreted according to diverse theoretical and ideological frameworks; and 3) the ways data are interpreted shape the kinds of action (or inaction) undertaken. Responses depend on the relative power of the salient political forces and state, class, and other institutional interests, including economic elites, religious institutions, lawmakers and civil servants, industrial workers, rural laborers, unions, social movements, and other groups. The interaction of these forces occurs through political parties, civil society alliances, and/or conflict; the state responds to these efforts in a manner that can be either supportive or quashing. This historical perspective makes plain the real political choices and challenges in enacting *CGG's* recommendations today.

We can enrich this perspective by considering how the ideas of Prussian physician Rudolf Virchow (1821-1902) might enhance *CGG's* influence. Founder of cellular pathology, Virchow was radicalized by his firsthand investigation of a devastating typhus epidemic among Polish peasants and by his participation on the barricades of the 1848 Berlin uprising. In calling for democracy as the prime strategy for resolving the epidemic, Virchow pioneered the integration of the societal (structural, political, and medical) determinants of health perspective with the special role to be played by physicians in decrying the conditions of poverty and deprivation that lead to disease.

Given their various roles as caregivers, anthropological observers, and scientists, Virchow deemed health workers to be "the natural advocates of the poor."[36] Following from Virchow's dictum two centuries later, even though the CSDH admirably consulted a range of civil society actors, *CGG* is ultimately the work of public health professionals. As Virchow pointed out, health workers combine their first-hand witnessing of suffering with their compelling

[36] Rudolf Virchow, "The Aims of the Journal 'Medical Reform'," in *Collected Essays on Public Health and Epidemiology*, ed. L.J. Rather (1848; Canton, MA: Science History Publications, 1985), 4.

legitimacy as town criers. And yet, Virchow was also fully conscious that public health voices had little value absent deep engagement in political activism.

**Where is the Politics of Power and Accountability?**

According to WHO Director-General Margaret Chan, the Commission's principal finding is straightforward: "The social conditions in which people are born, live, and work are the single most important determinant of good health or ill health, of a long and productive life, or a short and miserable one. … This ends the debate decisively."[37] If *CGG* echoes Virchow's understanding of the critical factors shaping health and disease—and does a magisterial job of documenting the existence and consequences of health inequity—it is, unlike Virchow, "profoundly apolitical."[38] The report says almost nothing about the *causes* of the "causes of the causes," [39] viz., what creates inequity in the first place.

This silence is most evident in *CGG*'s amorphous understanding of power and of the paths to achieving a fairer distribution of wealth and resources. Empowerment is addressed in terms of civic identity, freedom and autonomy, societal participation of women and marginalized populations (especially indigenous peoples), and ensuring "fair representation in decision-making about how society operates." [40] These are all significant questions of inclusion.

To make such empowerment a reality would be transformative indeed. Yet *CGG* remains vague on *how* more representative control over societal decisions and resources might come to be; it resorts to a fuzzy convergence of top-down (presumably through laws and policies) and bottom-up (through engagement of communities and civil society) approaches. Furthermore, the part played by social movements in small and momentous social and political changes, past and present, at local, national, and global levels, is relegated a few anodyne lines at the end of a chapter.

To be fair, in recognizing the importance of local context, the report avoids prescribing particular strategies for change. Still, the numerous boxes outlining experience and success in "political empowerment," from India's 1993 constitutional amendment reserving one-third of village council seats to women, to Venezuela's *Barrio Adentro* program, which accomplishes health care rights for the marginalized, are denuded of the political struggles behind these developments.[41]

Moreover, *CGG* does not match the groups needing empowerment against those who wield excessive power, and it is timid on how the equitable sharing of power within and across societies could be reached. Again and again, the report calls for fairness, participation, and protection—in the workplace, community, and public sphere—without naming who and what are the forces and institutions creating and perpetuating inequitable conditions in the first place.

In a chapter on "market responsibility," *CGG* tiptoes around the role of markets, capital, and corporate power. Recognizing that market-driven globalization has had damaging consequences, it discourages "wholesale privatization" of certain public goods, and it calls for "fair participation" in trade and investment agreements and global economic institutions. [42] But it only skims over *how* market forces affect health equity. When CGG invokes the most powerful actors at the global level, such as the WTO, transnational corporations (TNCs), and owners of financial capital, it does so in neutral, often naïve terms. For

[37] Margaret Chan, *Launch of the Final Report of the Commission on Social Determinants*, www.who.int (accessed November 15, 2008).

[38] Navarro, "What We Mean by Social Determinants of Health," 15.

[39] A term frequently invoked by CSDH Chair Sir Michael Marmot.

[40] CSDH, *Closing the Gap*, 158.

[41] Charles L. Briggs and Clara Mantini-Briggs, "Confronting Health Disparities: Latin American Social Medicine in Venezuela," *American Journal of Public Health*, 99, 2009, 549–55.

[42] CSDH, *Closing the Gap*, 144.

example, TNCs—e.g., Wal-Mart, ExxonMobil—are mentioned as having larger revenues than the GDPs of most countries, and the report proposes that corporate power "must be accountable to the public good as well as dedicated to private economic ends."[43]

This optimistic assertion belies the reality that private sector interests are *by definition* only accountable to their private owners/shareholders. TNCs have profited enormously (and are incentivized to do so) by flouting laws, exploiting workers, and contaminating the environment precisely *because they lack societal accountability*.[44] Since publicly-traded corporations have a primary fiduciary responsibility (that is, are legally bound) to make profits for their shareholders, any impediments to profit-making violate this obligation and are subject to legal action. Goodwill or voluntary corporate responsibility measures are thus patently insufficient to protect health and well-being. As Nobel prize-winning economist Milton Friedman put it, "asking a corporation to be socially responsible makes no more sense than asking a building to be."[45]

CGG advocates two avenues of action to make the market "responsible." One is 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. This is a fine start, but with several large caveats. On one level, this recommendation assumes that public health representation would reflect a health equity approach, forgetting that there are conflicting public health frameworks (recall Villermé, Chadwick, and Engels) based on markedly different principles (e.g., market incentives, cost-effectiveness, social justice) and which generate diverse courses of action. In addition, HEIAs exclude existing policies from assessment, greatly minimizing their impact. Most importantly, this recommendation presumes that the mere presence of public health voices and HEIA tools will alter the politics of decision-making, disregarding how decisions are made, by whom, and to what ends. These are all profoundly political issues, tied to the forces wielding power in the larger economic order.

Second, *CGG* calls for resurrecting the state's primary role in providing services basic to health (such as water and sanitation) and in regulating others that affect health (food, tobacco, and alcohol).[46] Again, this is an important step, but it is far too limited in scope. After all, as Amartya Sen reminds us, even Adam Smith recognized that free markets inherently generate winners and losers and that these inequities need to be addressed through public provision of education and social services.[47] Given the reach of the CSDH's social determinants framework, many more aspects of living and working conditions discussed throughout CGG rightfully belong under the auspices of the state and ought to be explicitly cited.

*CGG* could solidify its stance on the vital role of the public sector by drawing on a human rights approach.[48] Most countries have already recognized the governmental responsibility to "respect, protect, and fulfill" the human right to health.[49] Over two-thirds of all countries have health or health care-related rights enshrined in their constitutions.[50] These are either explicitly or

[43] CSDH, *Closing the Gap*, 133.
[44] People's Health Movement, Medact, and Global Equity Gauge Alliance, *Global Health Watch 2005–2006: Alternative World Health Report* (London: Zed Books, 2005).
[45] Milton Friedman, *Who's Who*, www.thecorporation.com (accessed December 5, 2007).
[46] CSDH, *Closing the Gap*, 138.
[47] Amartya Sen, "Capitalism beyond the Crisis," *The New York Times Review of Books*, 56, no. 5, 2009.
[48] Paul Hunt, "Missed opportunities: human rights and the Commission on Social Determinants of Health," *Global Health Promotion*, 16, 2009, 36–41.
[49] Sofia Gruskin and Daniel Tarantola, "Health and Human Rights," in *Perspectives on Health and Human Rights*, eds. Sofia Gruskin, Michael A. Grodin, George J. Annas, and Stephen P. Marks (New York: Routledge Press, 2005).
[50] Eleanor D. Kinney and Brian A. Clark, "Provisions for health and health-care in the constitutions of the countries of the world," *Cornell International Law Journal*, 37, no. 2, 2004, 285–355.

implicitly based on societal determinants of health, including adequate education and housing, non-discrimination on the basis of racial/ethnic origins and other factors, and fair employment. CGG could bolster its advocacy for public sector provision and regulation if it called for: a) enforcement of existing national and human rights instruments as a baseline for realizing health equity; and b) an end to the multiple, nefarious private sector practices that impede human rights.

Most of all, the very term "market responsibility" is an oxymoron; elected entities are accountable/responsible but markets are not. Nor, for that matter, are private foundations.[51] Lamentably, *CGG* sidesteps the lack of accountability of large philanthropies, which have become powerful global health actors. It only mentions that the Gates Foundation has at times had a larger annual budget than the WHO, without discussing the implications of this fact.[52] In avoiding analysis of the politics of accountability, *CGG* does not indict the private sector's vast and undemocratic power, which creates and perpetuates the very social injustices that are "killing at a grand scale."[53]

In order for the marketplace and private sector actors (and their political allies) to wield "benign" influence,[54] they would have to be *disempowered.* They would have to lose their overwhelming power to block the passage or enforcement of laws and regulations aimed at protecting the public good. This may be too impolite and impolitic an equation for the CSDH to make, but the report should certainly refrain from its assertion that health equity will be achieved "with the collaboration of private actors."[55]

Of course, these shortcomings are not so much a reflection of the CSDH as they are of the WHO, constrained as it is by consensus-politics and the dominance of powerful players (the largest donor governments, namely the United States and other G8 countries, whose global health policies are themselves heavily shaped by corporate interests).[56] When the WHO strayed from technocratic disease campaigns in the 1970s in an attempt to remake itself as a "world health conscience behind [progressive] national change,"[57] it was met with vindictive budget cuts by the U.S. government and displaced by the World Bank and other development agencies that favor the infusion of free market ideas into international health.[58] This challenge to WHO's authority continues to the present, amidst the proliferation of public-private partnerships, philanthropic foundations, corporate actors, and other private interests in global health.[59]

Surely *CGG* cannot be as incendiary as Engels! Still, it could go much further in showing how the private sector and owners of capital have created and perpetuated much of the health inequity that exists in the world and that realizing most CGG recommendations is contingent upon reigning in the power of the market.

## Making it Political: What is to be Done?

Despite these limitations, *CGG* shows promise in taking up socioeconomic redistribution as a priority. The report calls for progressive taxation, debt relief, and equitable allocation of public

[51] Anne-Emanuelle Birn, "Gates's Grandest Challenge: Transcending Technology as Public Health Ideology," *The Lancet*, 366, 2005, 514-519; People's Health Movement, Medact, and Global Equity Gauge Alliance, *Global Health Watch 2: An Alternative World Health Report* (London: Zed Books, 2008).
[52] CSDH, *Closing the Gap*, 174.
[53] See Navarro, "What We Mean by Social Determinants of Health"; Kim, Millen, Irwin, and Gershman, eds., *Dying for Growth*; Fort, Mercer, and Gish, eds., *Sickness and Wealth*.
[54] CSDH, *Closing the Gap*, 144.
[55] CSDH, *Closing the Gap*, 109.
[56] Navarro, "What We Mean by Social Determinants of Health."
[57] WHO, *Introducing WHO* (Geneva, Switzerland: World Health Organization, 1976), 80–81; see also Halfdan Mahler, "A Social Revolution in Public Health," *WHO Chronicle*, 30, no. 12, 1976, 475–480.
[58] Anne-Emanuelle Birn, "The Stages of International (Global) Health: Histories of Success or Successes of History?" *Global Public Health*, 4, no. 1, 2009, 50–68.
[59] Birn, Pillay, and Holtz, *Textbook of International Health.*

resources. In particular, it emphasizes the development and expansion of welfare states (while largely avoiding use of the actual term) that provide comprehensive and universal services and protections to their populations across the lifecourse.

If the WHO is able to put its clout behind such recommendations, it may have a bona fide chance of helping to diminish health inequity. As emphasized above, governments need the backing of social justice movements, unions, political parties, and other actors to enable adoption of these measures. These forces must also struggle at the global level to ensure that TNCs and other private players, as well as financial and trade institutions, are strongly regulated and prevented from blocking these reforms.[60] This is no mean feat, but through a combination of concerted and persistent political struggle, including activism on the streets, advocacy across organizations and continents, and formal electoral politics, it is potentially achievable.

## History, Politics, and Welfare States

*CGG* makes a strong case for placing the welfare state at the center of the societal determinants of health project by looking at the "historical experience"[61] of various protective and redistributive societies. But the report sanitizes the past. The section titled "building on solid foundations" presents a set of decontextualized and depoliticized principles and goals, based on the Nordic model. *CGG* also makes note of how "some low-income countries, Costa Rica, China, India (State of Kerala), and Sri Lanka, have achieved a level of good health out of all proportion to expectation based on their level of national income. … Cuba is another example."[62]

While the important point is made that "good and equitable health do not depend on a high level of nation wealth,"[63] the report never states *how* these societies have actually achieved their health success. The lessons to be learned are summarized as five "shared political factors:"[64]

- historical commitment to health as a social goal
- social welfare orientation to development
- community participation in decision-making processes relevant to health
- universal coverage of health services for all social groups
- intersectoral linkages for health

Yet there is no mention of political struggle nor of how these principles emerged and were implemented. Surely we are not to believe that welfare states materialize from policymakers' *deus ex machina* values and actions or the commandments of enlightened leaders. Universalism is not simply a slogan: depending on where and when, revolution, civil war, activism in the streets, great personal sacrifice, and many years of commitment and alliances working against enormous odds have enabled these policies and societal changes.

In each of the settings cited, long-term political struggle has been needed, whether arising from: armed revolution (in the case of Cuba); extremely high union participation and activism –between 70 and 95 percent of the active labor force (itself resulting from political struggle)—combined with election of political parties with social democratic values (in Nordic countries); 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). Of course, each of these histories is far more complicated,[65]

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[60] Ronald Labonté, Ted Schrecker, Vivien Runnels, and Corinne Packer, eds., *Globalization and Health: Pathways, Evidence and Policy,* (New York: Routledge, 2009).

[61] CSDH, *Closing the Gap*, 33.

[62] Ibid. For a thoughtful analysis on this issue, see James C. Riley, *Low Income, Social Growth, and Good Health: A History of Twelve Countries*, (Berkeley: University of California Press, 2007).

[63] Ibid.

[64] Irwin and Scali, *Action on the Social Determinants of Health* cited in CSDH, *Closing the Gap*, 33.

[65] For example, eugenic policies were intimately linked to the building of the Scandinavian welfare state. It was

and none of these societies has eliminated inequity. Nevertheless they all share the experience of concerted political struggle to redistribute power, money, and resources more equitably throughout society.

Nor does this presentation of shared factors help explain the political context of social inequalities in health in countries with welfare states during more recent times.[66] For example, why does Sweden's welfare state cushion the health of its population against poverty better than Britain's does?[67] And why have primary health care initiatives worked to improve equity in some countries (e.g., Cuba) but not in others (e.g., China)?[68]

To be sure, *CGG* does not discuss the details or range of existing welfare states. Esping-Andersen has differentiated among welfare regimes (liberal, conservative, and social–democratic), while other typologies focus on the role of political parties and social movements, the varieties of capitalism (whether market economies are coordinated or liberal), or whether and how particular protectionist policies, such as family support and income security, derive from employment or residency/citizenship.[69] While space considerations may have prevented this discussion in *CGG*, a few key points are highlighted here.

First, the much-cited social democratic Nordic model recognizes (though *CGG* does not) that the market inherently produces inequity and pays attention only to short-term profits, not long-term social consequences. This is why Nordic welfare states, and other variants of social democracy, prioritize social policies for their citizens and residents (as opposed to societies which shore up big business[70]) and government regulation of the private sector. In other words, the social-democratic welfare state is considered central to the functioning of society. There is considerable debate about whether Nordic countries are thriving and sustainable or declining, but significant evidence shows that strong social welfare states can foster economic growth while maintaining equitable distribution.[71]

Second, the relationship between welfare states and health is complex[72] and may unfold over many years. When evaluated according to the impact of particular social policies, strong welfare states are associated with positive health

Denmark that passed Europe's first sterilization law in 1929. See Gunnar Broberg and Nils Roll-Hansen, eds., *Eugenics and the Welfare State: Sterilization Policy in Norway, Sweden, Denmark, and Finland* (Lansing: Michigan State University Press, 1997).

[66] Vicente Navarro and Leiyu Shi, "The Political Context of Social Inequalities and Health," *Social Science and Medicine*, 52, no. 3, 2001, 481–91; Vicente Navarro, ed., *The Political Economy of Social Inequalities: Consequences for Health and Quality of Life*, (Amityville, NY: Baywood Publishing Company, Inc, 2002).

[67] Chris Jones, Bo Burström, Anneli Marttila, Krysia Canvin, Margaret Whitehead, "Studying Social Policy and Resilience in Families Facing Adversity in Different Welfare State Contexts: Britain and Sweden," *International Journal of Health Services*, 36, no. 3, 2006, 425–42.

[68] Linda Whiteford and Laurence Branch, *Primary Health Care* in *Cuba: The Other Revolution,* Lanham, MD: Rowman and Littlefield, 2008); David Blumenthal and William Hsiao, "Privatization and its Discontents—The Evolving Chinese Health Care System," *New England Journal of Medicine*, 353, no. 11, 2005, 1165–70.

[69] Gøsta Esping-Andersen, *The Three Worlds of Welfare Capitalism,* (Princeton, NJ: Princeton University Press, 1990); T.A. Eikemo and C. Bambra, "The Welfare State: A Glossary for Public Health," *Journal of Epidemiology and Community Health*, 62, no. 1, 2008, 3–6.

[70] For example, in the recent financial crisis, even a right-leaning Swedish government has strengthened unemployment policies but let the automobile company Saab succumb to market forces, while North American governments are providing far greater economic support to failing automobile companies than to struggling citizens.

[71] Mikael Nygård, 2006, "Welfare-Ideological Change in Scandinavia: A Comparative Analysis of Partisan Welfare State Positions in Four Nordic Countries, 1970-2003," *Scandinavian Political Studies*, 29, no. 4, 356–85.

[72] Jason Beckfield and Nancy Krieger, "Epi + demos + cracy: Linking Political Systems and Priorities to the Magnitude of Health Inequities—Evidence, Gaps, and a Research Agenda," *Epidemiologic Reviews*, May 27, 2009 [Epub ahead of print].

outcomes,[73] but whether this is due to politics or policies is debated.[74] In addition, little attention has been paid to the long-term effects of *both* welfare state policies *and* politics. It may be that the very political activism that builds welfare states has other positive outcomes, including political engagement in other spheres that affect health and the embodied[75] positive health characteristics of *bona fide* political participation.

A third key issue overlooked by *CGG* in citing Nordic countries as exemplars is the extent to which they continue to struggle to reduce inequalities. For example, the Swedish welfare state has explicitly addressed socioeconomic gradients, discrimination, and living conditions, as well as meaningful and equitable citizen participation at all levels of public life.[76] Despite having achieved one of the lowest levels of health inequities in the world, Sweden remains highly concerned about persistent differences.[77] Creating health equity is an ongoing effort even, or especially, in the societies that have accomplished the most.

In those countries with less flexibility to regulate the market, where there is greater influence of foreign investors, where the market's inherent inequities are not addressed by political regimes or social policy, and where there are greater extremes of poverty and inequity—in other words where there are far larger obstacles, both internal and external, to the democratization of power—the building of welfare states is an even bigger challenge.[78] Some developing countries have skeletal states, where government involvement in extending social protection across the lifecourse remains a pipe dream; in settings where there are high levels of exploitation, corruption, oppression, and violence, the formation of protective welfare states is severely impeded.

As *CGG*'s examples illustrate, this does not mean that a high GDP per capita is a welfare state precondition. Still, welfare states of the global South—such as the precocious yet exclusionary and segmented welfare states characteristic of many Latin American countries—are especially vulnerable to economic crisis and global economic exigencies.[79]

In recent years, this dilemma has led global development policymakers to focus on targeted poverty alleviation programs rather than universal social policies. Certainly, targeted programs could be seen as "efficient" in some contexts; they are less objectionable to moneyed interests, and potentially easier to monitor and evaluate than more comprehensive programs. But even if those

[73] Olle Lundberg, Monica Åberg Yngwe, Maria Kölegård Stjärne, Jon Ivar Elstad, Tommy Ferrarini, Olli Kangas, Thor Norström, Joakim Palme, and Johan Fritzell, for the NEWS Nordic Expert Group, "The Role of Welfare State Principles and Generosity in Social Policy Programmes for Public Health: An International Comparative Study," *The Lancet*, 372, no. 9650, 2008, 1633–40; Haejoo Chung and Carles Muntaner, "Welfare State Matters: A Typological Multilevel Analysis of Wealthy Countries," *Health Policy*, 80, no. 2, 2007, 328–39.

[74] Olle Lundberg, Commentary: Politics and Public Health—Some Conceptual Considerations Concerning Welfare State Characteristics and Public Health Outcomes," *International Journal of Epidemiology,* 2008; 37: 1105 - 1108; Carles Muntaner, Carme Borrell, Albert Espelt, Maica Rodríguez-Sanz, M. Isabel Pasarín, Joan Benach, and Vicente Navarro, "Politics or policies vs. politics and policies: a comment on Lundberg," *International Journal of Epidemiology* Advance Access published on June 2, 2009.

[75] Nancy Krieger, "Embodiment: A Conceptual Glossary for Epidemiology," *Journal of Epidemiology and Community Health*, 59, no. 5, 2005, 350–55.

[76] Signild Vallgarda, "Health Inequalities: Political Problematizations in Denmark and Sweden," *Critical Public Health*, 17, no. 1, 2007, 45–56.

[77] Government of Sweden, *The National Public Health Strategy for Sweden in Brief* (Stockholm: Swedish National Institute of Public Health, 2007), 1.

[78] Nita Rudra, *Globalization and the Race to the Bottom in Developing Countries: Who Really Gets Hurt?* (Cambridge and New York: Cambridge University Press, 2008); Stephen Haggard and Robert R. Kaufman, *Development, Democracy and Welfare States: Latin America, East Asia, and Eastern Europe*, (Princeton, NJ: Princeton University Press, 2008).

[79] Juliana Martínez Franzoni..*Domesticar la incertidumbre en América Latina: Mercado laboral, política social y familias*. (San José: Universidad de Costa Rica, Instituto de Investigaciones Sociales, 2008).

targeted "do better," they will still be poor in relative terms, and the needs of the "near poor" will remain neglected. The World Bank's own studies have shown that targeted programs rarely reach the extremely poor, further marginalizing them.[80] Targeted programs are among the first to be eliminated during times of economic difficulty, precisely because they lack the broad political constituency of universal programs.

*CGG* recognizes that targeting should only be used as a backup and not a substitute for universal policies. That said, addressing societal inequalities *includes* alleviating poverty.[81] Intertwining *both* universal programs *and* additional, focused efforts to deal with those suffering the greatest health inequity would help to reduce targeting's aforementioned problems.

An important caution regarding the expansion of welfare states: while civil society groups, as *CGG* points out, are fundamentally important actors in democratic political processes (including in ensuring public accountability), it is important *not* to conflate civil society participation with NGO provision of public services. NGOs can be more efficient, flexible, imaginative, and humane than government providers, and are a (temporary) necessity when states are corrupt, repressive, or absent/deficient. However, like private sector actors, NGOs are "unaccountable, undemocratic, and to the extent to which they exist because appropriate, democratically-determined structures for public service have been destroyed, may be a dangerous development."[82] They can also fragment delivery of social services, undercut democratic decision-making, exacerbate inequality, and drain resources and staff from public services.[83]

### Where's the Politics in Political Will?

While *CGG's* optimism about achieving social protection across the lifecourse is palpable, it remains hopelessly fixed on the concept of political will. The report cautions:

> *This is a long-term agenda, requiring investment starting now, with major changes in social policies, economic arrangements, and political action. At the centre of this action should be the empowerment of people, communities, and countries that currently do not have their fair share. The knowledge and the means to change are at hand and are brought together in this report. What is needed now is the political will to implement these eminently difficult but feasible changes. Not to act will be seen, in decades to come, as failure on a grand scale to accept the responsibility that rests on all our shoulders.*[84]

The term "political will," while sounding reasonable, is undefined, superficial, and ultimately meaningless, perhaps contributing to its popularity.[85] It may refer to the decontextualized actions of particular leaders, legislators, or policymakers, the cultural values of a society, or a *fait accompli*.[86]

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[80] Davidson Gwatkin, Adam Wagstaff, and Abdo Yazbeck, eds., *Reaching the Poor with Health, Nutrition, and Population Services: What Works, What Doesn't and Why* (Washington, DC: World Bank, 2005).

[81] Nancy Krieger, "Why Epidemiologists Cannot Afford to Ignore Poverty," *Epidemiology*, 18, no. 6, 2007, 658–63.

[82] Birn, Pillay, and Holtz, *Textbook of International Health*, 111.

[83] James Pfeiffer, "International NGOs and Primary Health Care in Mozambique: The Need for a New Model of Collaboration," *Social Science and Medicine*, 56, no. 4, 2003, 725–38.

[84] CSDH, *Closing the Gap*, 23.

[85] Michael Reich, "The Political Economy of Health Transitions in the Third World," in *Health and Social Change in International Perspective*, eds. Lincoln C. Chen, Arthur Kleinman, and Norma C. Ware (Boston, MA: Harvard School of Public Health, 1994).

[86] Invoking political will as the key to health success has previously proven a dead end. The Rockefeller Foundation began such an effort in the mid-1980s with its study of *Good Health at Low Cost* in Costa Rica, China, Kerala, and Sri Lanka. When it became clear that the political will necessary for achieving healthy societies rested on political struggles that brought

At best, political will is an evasive euphemism, at worst an illusion. Troublingly, political will is used eleven times in *CGG*, but "political struggle" is never mentioned. Social class is referred to only in terms of data collection. The report also refrains from referring to global capitalism, even though this long-accepted moniker for the current political-economic order is perhaps the most important societal determinant of all. In the end, it seems, invoking political will as a cure-all assumes an audience of policymakers. If Villermé aimed his approach to resolving health inequities at the bourgeoisie (do nothing but encourage more capitalist development), Engels spoke to the proletariat (foment revolution), and Chadwick to "enlightened" legislators and businessmen (enact sanitary technocratic measures), *CGG*'s recommendations, in calling for "all our shoulders" [87] to come together to create the necessary political will, seem most geared to Chadwick's audience: policymakers, professionals, and an enlightened private sector, a reductionist approach indeed.

**Room for Hope?**

But all is not lost. In its understated references to social justice movements and organizations, its more pointed discussions of civil society's role, and its advocacy of social redistribution and social protection across the lifecourse, *CGG* leaves the door open for more transformative change. In a propitious accident of timing, *CGG* was released almost simultaneous to the unfolding bankruptcy (double entendre intended) of the global financial system, offering ample opportunities for concerted political efforts for reform of both national and international economic policy. Since WHO recognizes that "nearly all social determinants of health fall outside the direct control of the health sector,"[88] it is time for WHO to take leadership in voicing the importance of political struggle for reducing health inequities.

Why not, then, explicitly support social democratic and social justice approaches that, through political struggle, seek to reduce health inequity? At the very least, WHO should reorient its own programs so that most resources are aimed at reducing health inequity through social justice efforts. It could advocate for the UN to augment the power of its most under-recognized agency, the International Labour Organization, to enable it to effectively monitor and improve work conditions throughout the world.

At the level of global civil society, WHO could back a renewal of labor solidarity and activism, which, in a previous era of globalization circa 1900, put an end to child labor in many countries, instituted shorter work days, and improved factory conditions, albeit excluding colonized populations, women, immigrants, and racial/ethnic minority populations. With more than one billion workers across the world still unprotected by labor legislation, over one million occupational deaths, and an estimated 250 million child laborers,[89] such a renewed international movement is sorely needed. No-strings-attached funding from the UN, called for by WHO, would provide a supportive first step, consistent with *CGG's* recommendations relating to fair employment and decent work.

In terms of global finance, the report could push for political mobilization, within countries and transnationally, to create a new equitable system of global governance based upon fair terms of trade and democratic distribution of political and economic power that is socially and environmentally sustainable.[90]

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socialist or social democratic political parties to power, the initiative was abandoned. See Scott B. Halstead, Julia A. Walsh, and Kenneth S. Warren, eds., *Good Health at Low Cost, A Rockefeller Foundation Conference Report* (New York: The Rockefeller Foundation, 1985); Birn, "Gates's Grandest Challenge."

[87] CSDH, *Closing the Gap*, 23.

[88] Chan, *Launch of the Final Report*.

[89] Birn, Pillay, and Holtz, *Textbook of International Health*, Chapter 9.

[90] Benatar, Gill, and Bakker, "Making Progress in Global Health."

## Quo Vadis? Reform as Revolution

Over 100 years ago, the Polish revolutionary and socialist philosopher Rosa Luxemburg posed the question of whether reform (change from within) was useful and possible or whether it impeded revolution (change from without).[91]

Today, many regard the reform versus revolution dichotomy to be false or at least exaggerated, instead viewing effective redistributive reforms—especially the creation of welfare states with universal rights to safe housing, clean water and sanitation, living wages, universal education, health care, and nondiscrimination—as the scaffolding of structural change. Yet for those who believe that armed struggle is the only way to build societies based on social justice, peace negotiations and electoral processes may seem grossly inadequate.

Certainly peaceful political mobilization in the wake of armed struggle can lead to mixed results, such as in Zimbabwe where, after a successful armed liberation movement in the 1970s, early attempts at redistribution were later followed by increasingly repressive measures; in South Africa where decades of anti-apartheid activism and armed struggle yielded to democracy in the 1990s and only slow gains in decreasing inequity; and in El Salvador, where an armed struggle was demobilized under mandated peace negotiations in the early 1990s, and it took almost two decades of electoral struggle for the social-justice-oriented FMLN party to be voted into power (2009).

Making revolution through redistributive reforms is a far greater task in countries plagued by civil or regional wars (most of which are fuelled or exacerbated by inequality in, and conflict over, control and distribution of resources—land, minerals, oil, etc., such as in Colombia or the Democratic Republic of the Congo); where there are repressive regimes, as in Myanmar or Sudan; where corruption levels are soaring, as in Nigeria and the Russian Federation; and where the power of private enterprise is firmly entrenched, as in the United States and South Africa.

But as the examples of South Korea, Brazil, and Sri Lanka show, even countries marked by great violence, corruption, or repression can overcome this legacy to build effective welfare states.[92] In that sense, reform as revolution *may* be possible. The dangers of counter-reaction also seem to be abating, even as they depend on whether the United States continues to use politico-military force to shore up its "eroding global position" and create global disorder.[93]

Indeed, increasing numbers of countries are undergoing reform as revolution, with Latin America at the vanguard. This development is worth far more than a passing reference: the surge of social-justice-oriented political parties elected to power at both national and local levels in Ecuador, Paraguay, Uruguay, Venezuela, Brazil, Bolivia, and El Salvador offers the best contemporary chance for truly "closing the gap in a generation."

How might this transpire? In the spirit of *CGG*'s ambitious gaze at the past from the vantage point of 2040, I propose a table of

[91] Rosa Luxemburg, *Social Reform or Revolution*, www.marxists.org (accessed March 17, 2009). Espousing the latter position, leading to her participation in the Berlin revolution, cost her her life in 1919 when she was captured by German authorities and tortured to death.

[92] Ito Peng and Joseph Wong, "Institutions and Institutional Purpose: Continuity and Change in East Asian Social Policy," *Politics & Society*, 36, no. 1, 2008, 61–88; Haggard and Kaufman, *Development, Democracy and Welfare States*; Paulo Eduardo M. Elias and Amelia Cohn, "Health Reform in Brazil: Lessons to Consider," *American Journal of Public Health*, 93, no. 1, 2003, 44–48; Kirsty McNay, Regina Keith, and Angela Penrose, *Bucking the Trend: How Sri Lanka has Achieved Good Health at Low Cost—Challenges and Policy Lessons for the 21st Century*, (London: Save the Children, 2006); Carles Muntaner, René M. Guerra Salazar, Sergio Rueda, Francisco Armada, "Challenging the Neoliberal Trend: The Venezuelan Health Care Reform Alternative," *Canadian Journal of Public Health*, 97, no. 6, 2006, I19–24.

[93] Eric Hobsbawn, *On Empire: America, War, and Global Supremacy* (New York: Pantheon Books, 2008), 90.

alternate milestones taking into account the possibilities opened up by this critique.

As Mordcha, the innkeeper from *Fiddler on the Roof* wryly noted, "If the rich could hire others to die for them, we, the poor, would all make a nice living." Recognizing that political struggle is central to realizing the courageous social justice goals of *Closing the Gap, we* might avoid Mordcha's paradoxical trajectory.

**CSDH Milestones and Alternate Milestones Towards Health Equity**

Source for *CSDH Milestones*: CSDH, *Closing the Gap*, 198; *Alternate Milestones*: Author.

| Date | Milestone |
|---|---|
| 2009 | *CSDH Milestone*: Meetings of Commissioners and social determinants of health champions to advance global plan for dissemination and implementation of Commission recommendations. |
| | *Alternate Milestone*: Commissioners decide to expand their ranks so that ten new slots go to social justice groups around the world. |
| 2008–09 | *CSDH Milestone*: Creation of post-Commission global alliance to take forward the social determinants of health agenda in partnership with WHO. |
| 2010 | *Alternate Milestone*: After recession reaches crisis proportions (with unemployment rates exceeding 25% across the world and daily protests in most countries), the G-20, EU, G-8, G-77, and Obama administration call on the Commission to play a critical role in international economic social justice plan. |
| 2008–09 | *CSDH Milestone*: Economic and social costing of Commission recommendations and costs of not taking action. |
| 2009–10 | *Alternate Milestone*: Leading global governance groups and international financial institutions agree that every decision they take must undergo a societal determinants of health equity impact assessment. |
| 2009 | *CSDH Milestone*: World Health Assembly resolution on social determinants of health and health equity. |
| 2010 | *Alternate Milestone*: World Health Assembly (WHA) resolution on welfare states: 193 member countries plus Taiwan –pushed domestically by unions, the growing ranks of social democratic parties, and social movements—agree to establish or strengthen social welfare states, consistent with the most equitable social protection standards (according to robust and up-to-date evidence) and commit themselves to continuous welfare state reform towards improving equity. |
| 2008–13 | *CSDH Milestone*: Research funders progressively dedicate more resources to research on social determinants of health, especially in areas highlighted by the Commission. |
| | *Alternate Milestone*: Pressed by progressive researchers and social justice movements, the World Bank and IMF completely reorient their mission, and carry out a societal determinants of health equity impact assessment on every loan, policy, and advisory consultation. |

*Continued on the next page*

| Date | Milestone |
|---|---|
| 2008–13 | *CSDH Milestone*: Increasing numbers of countries adopt a social determinants of health approach to health equity and develop and implement social determinants of health policies, so that by 2013 at least 50% of all low-, middle-, and high-income countries have a committed plan for action to reduce health inequity through action on the social determinants of health, with evidence that they are implementing the plan. |
| | *Alternate Milestone*: More and more countries adopt a welfare state: by 2013, 170 countries now have universal free education from pre-school through university, 150 countries have enforceable family living wage policies, 90 countries have reduced greenhouse emissions to 1932 levels, all countries have ensured that everyone in the population lives less than a three-minute walk to green space, 165 countries have universal social protection systems across the life course (social security, unemployment benefits, family benefits, living wages, parental leave, workplace safety and health protections, and universal health care). All countries have gender equity policies in place. |
| 2010 | *CSDH Milestone*: The Economic and Social Council, supported by WHO, prepare for consideration by the UN the adoption of health equity as a core global development goal, with appropriate indicators to monitor progress both within and between countries. |
| | *Alternate Milestone*: The UN is renamed the United Nations for Equity and Social Protection. |
| 2015 | *CSDH Milestone*: MDG target date; review of progress from health equity perspective: second 5-yearly global health equity report and Global Forum. |
| | *Alternate Milestone*: New International Equitable and Sustainable Economic Order fully in place. |
| 2020–2040 | *CSDH Milestone*: 5-yearly reviews of progress on reducing health inequities within and between countries. |
| | *Alternate Milestone*: Graduate students across the world study the history of the implementation of *Closing the Gap in a Generation*. Given the lag effect of social welfare states on social well-being, the data monitoring teams stay in place until 2040, at which point they propose to the London Underground that announcements to “mind the gap” be suspended, as there is no more gap to mind. |

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