

**WHAT WE MEAN BY
SOCIAL DETERMINANTS OF HEALTH**

Vicente Navarro

This article analyzes the changes in health conditions and quality of life in the populations of developed and developing countries over the past 30 years, resulting from neoliberal policies developed by many governments and promoted by the World Bank, International Monetary Fund, World Health Organization, and other international agencies. It challenges interpretations by the analysts of “globalization,” including the common assumption that states are disappearing. The author shows that what has been happening is not a reduction of state interventions but a change in the nature and character of those interventions, resulting from major changes in class (and race and gender) power relations in each country, with establishment of an alliance between the dominant classes of developed and developing countries—a class alliance responsible for the promotion of its ideology, neoliberalism. This is the cause of the enormous health inequalities in the world today. The article concludes with a critical analysis of the WHO report on social determinants of health, applauding its analysis and many of its recommendations, but faulting it for ignoring the power relations that shape these social determinants. It is not *inequalities* that kill people, as the report states; it is *those who are responsible for these inequalities* that kill people.

**INTRODUCTION: WELCOMING THE WHO COMMISSION
ON SOCIAL DETERMINANTS OF HEALTH**

Thank you very much for inviting me to give the inaugural speech at the Eighth European Conference of the International Union of Health Promotion and Education, taking place in this beautiful setting in Turin, Italy.¹ Let me start by

¹ Speech to the Eighth IUHPE European Conference, September 9, 2008.

congratulating you on choosing as a major theme of this conference the social determinants of health. As you know, the WHO Commission on Social Determinants of Health has just published its long-awaited report. The report has, deservedly, created worldwide interest and within a few days has monopolized the health and medical news worldwide—with some notable exceptions such as the United States, where the report has barely been noticed in the media. I saluted the establishment of the WHO Commission and now applaud most of the recommendations in its report. But my enthusiasm for the report is not uncritical, and I will enlarge on this later in my presentation.

Let's start with some of the facts presented in the Commission's report, facts that should cause discomfort for any person committed to the health and quality of life of our populations, because the problems described in the report—how death and poor health are not randomly distributed in the world—are easily solvable. We know how to solve them. The problem, however, is not a scientific one. But before touching on this issue—the major theme of my talk—let's look at the facts.

To quote one statistic directly from the report: "A girl born in Sweden will live 43 years longer than a girl born in Sierra Leone." The mortality differentials among countries are enormous. But such inequalities also appear within each country, including the so-called rich or developed countries. Again, quoting from the report: "In Glasgow, an unskilled, working-class person will have a lifespan 28 years shorter than a businessman in the top income bracket in Scotland." We could add here similar data from the United States. In East Baltimore (where my university, the Johns Hopkins University, is located), a black unemployed youth has a lifespan 32 years shorter than a white corporate lawyer. Actually, as I have documented elsewhere (1), a young African American is 1.8 times more likely than a young white American to die from a cardiovascular condition. Race mortality differentials are large in the United States, but class mortality differentials are even larger. In the same study, I showed that a blue-collar worker is 2.8 times more likely than a businessman to die from a cardiovascular condition. In the United States, as in any other country, the highest number of deaths could be prevented by interventions in which the mortality rate of all social classes was made the same as the mortality rate of those in the top income decile. These are the types of facts that the WHO Commission report and other works have documented. So, at this point, the evidence that health and quality of life are socially determined is undeniable and overwhelming.

CHANGES IN POLITICAL, ECONOMIC, AND SOCIAL CONTEXTS OVER THE PAST 30 YEARS

Before discussing the results and recommendations of the WHO Commission, I want to analyze the changes we have seen in the world over the past 30 years—changes in the social, political, and economic contexts in which mortality inequalities are produced and reproduced. The most noticeable changes are those

that were initiated by President Reagan in the United States and by Prime Minister Thatcher in Great Britain in the late 1970s and early 1980s. During the period 1980–2008, we have seen the promotion of public policies throughout the world that are based on the narrative that (a) the state (or what is usually referred to in popular parlance as “the government”) must reduce its interventions in economic and social activities; (b) labor and financial markets must be deregulated in order to liberate the enormous creative energy of the market; and (c) commerce and investments must be stimulated by eliminating borders and barriers to the full mobility of labor, capital, goods, and services. These policies constitute the *neoliberal* ideology.

Translation of these policies in the health sector has created a new policy environment that emphasizes (a) the need to reduce public responsibility for the health of populations; (b) the need to increase choice and markets; (c) the need to transform national health services into insurance-based health care systems; (d) the need to privatize medical care; (e) a discourse in which patients are referred to as clients and planning is replaced by markets; (f) individuals’ personal responsibility for health improvements; (g) an understanding of health promotion as behavioral change; and (h) the need for individuals to increase their personal responsibility by adding social capital to their endowment. The past 30 years have witnessed the implementation of these policies and practices worldwide, including in the United States, in the European Union, and in international agencies such as the WHO. Such policies have appeared in the *Washington consensus*, in the *Brussels consensus*, and, indeed, in the *WHO consensus*, as evidenced by the *WHO Report 2000* on health systems performance (2, 3).

The theoretical framework for development of these economic and social policies was the belief that the economic world order has changed, with a globalization of economic activity (stimulated by these policies) that is responsible for unprecedented worldwide economic growth. In this new economic and social order, states are losing power and are being supplanted by a new, worldwide market-centered economy based on multinational corporations, which are assumed to be the main units of activity in the world today. This theoretical scenario became, until recently, dogma, applauded by the *New York Times*, the *Financial Times*, the *Economist*, and many other media instruments that reproduce neoliberal establishments’ conventional wisdom around the world.

While these organs of the financial establishment applaud the neoliberal scenario, there are those in the anti-establishment tradition (such as Susan George, Eric Hobsbawm, large sectors of the anti-globalization movement, and the World Social Forum, among others) that lament it. But they interpret the reality in the same way: that we are living in a globalized world in which the power of states is being replaced by the power of multinational corporations; the only difference is that while the establishment forces applaud globalization, the anti-establishment forces mourn it. The problem with this interpretation of reality is that both sides—the establishment and the anti-establishment forces—are wrong!

LOOK AT THE PRACTICE, NOT THE THEORY,
OF NEOLIBERALISM

We need to analyze the ideological assumptions underlying these interpretations of current realities. To start with, contrary to the claims of neoliberal theory, *there has been no reduction of the public sector in most OECD countries*. In most countries, public expenditures (as percentage of gross national product (GNP) and as expenditures per capita) have grown. In the United States, the leader of the neoliberal movement, public expenditures increased from 34 percent of GNP in 1980, when President Reagan started the neoliberal revolution, to 38 percent of GNP in 2007; and they increased from \$4,148 per capita in 1980 to \$18,758 per capita in 2007. We have also seen that in most OECD countries, there has been an increase rather than a decrease in taxes as percentage of GNP: in the United States, an increase from 35 percent in 1980 to 39 percent in 2007; or, without payroll taxes, an increase from 32 percent in 1980 to 36 percent in 2007. Actually, under President Reagan, the United States saw an increase in federal public expenditures from 21.6 percent to 23 percent of GNP, while taxes increased not once, but twice. As a matter of fact, Reagan increased taxes for a greater number of people (in peace time) than any other U.S. president. He reduced taxes for the top 20 percent of earners but increased taxes for everyone else. As John Williamson, the father of the neoliberal Washington consensus, wrote, “We have to recognize that what the U.S. Government promotes abroad, the U.S. government does not follow at home” (4).

What we are witnessing in recent days, with active federal interventions to resolve the banking crisis created by deregulation of the banking industry, is just one more example of how wrong is the thesis that states are being replaced by multinationals! States are not disappearing. What we are seeing is not a reduction of state interventions, but rather a change in the nature of these interventions. This is evident if we look at the evolution of public federal expenditures. In 1980, the beginning of the neoliberal revolution, 38 percent of these expenditures went to programs targeted to persons, 41 percent to the military, and 21 percent to private enterprises. By 2007, these percentages had changed quite dramatically: expenditures on persons declined to 32 percent, military expenditures increased to 45 percent, and expenditures in support of private enterprises increased to 23 percent. And all of this occurred before the massive assistance now going to the banking community (as a way of resolving the financial crisis) as approved by the U.S. Congress.

A similar situation is evident in the health care sector. We have seen further privatization of health services, with expansion of the role of insurance companies in the health sector supported by fiscal policies, from tax exemptions to tax subsidies that have increased exponentially. Similarly, the private management of public services has been accompanied by an increased reliance on markets, co-payments, and co-insurances. There has also been a massive growth of both

public and private investment in biomedical and genetics research, in pursuit of the biological bullet that will resolve today's major health problems, with the main emphasis on the biomedical model—and all of this occurs under the auspices and guidance of the biomedical and pharmaceutical industry, clearly supported with tax money.

THE CHANGING NATURE OF PUBLIC INTERVENTIONS: THE IMPORTANCE OF CLASS

A characteristic of these changes in public interventions is that they are occurring in response to changes in the distribution of power in our societies. Indeed, the changes have systematically benefited some groups to the detriment of others. Public interventions have benefited some classes at the expense of other classes, some races at the expense of others, one gender at the expense of the other, and some nations at the expense of other nations. We have seen a heightening of class as well as race, gender, and national tensions—tensions resulting from growing class as well as race, gender, and national inequalities. And I need to stress here the importance of speaking about class as well as race, gender, and national inequalities. One element of the postmodernist era is that class has almost disappeared from political and scientific discourse. Class analysis is frequently dismissed as antiquated, a type of analysis and discourse for “ideologs,” not for serious, rigorous scientists. As class has practically disappeared from the scientific literature, it has been replaced by “status” or other less conflictive categories. The disappearance of class analysis and class discourse, however, is politically motivated. It is precisely a sign of class power (the power of the dominant class) that class analysis has been replaced by categories of analysis less threatening to the social order. In this new scenario, the majority of citizens are defined as middle class, the vast majority of people being placed between “the rich” and “the poor.”

But classes do exist, and the data prove it. The two most important sociological scientific traditions in the western world are the Marxist and Weberian traditions, which have contributed enormously to the scientific understanding of our societies. Both traditions consider class a major category of power, and conflicts among classes a major determinant for change. To define class analysis as antiquated is to confuse antique with antiquated. The law of gravity is antique, but it is not antiquated. If you don't believe this, test the idea by jumping from a fourth floor window. And I am afraid that many analysts are jumping from the fourth floor. Forgetting or ignoring scientific categories carries a huge cost. One of them is an inability to understand our world.

Neoliberalism is the ideology of the dominant classes in the North and in the South. And the privatization of health care is a class policy, because it benefits high income groups at the expense of the popular classes. Each of the neoliberal public policies defined above benefits the dominant classes to the detriment of the dominated classes. The development of these class policies has hugely

increased inequalities, including health inequalities, not only between countries but within countries.

Another example of the cost of forgetting about class is that the commonly used division of the world into rich countries (the North) and poor countries (the South) ignores the existence of classes within the countries of the North and within the countries of the South. In fact, 20 percent of the largest fortunes in the world are in so-called poor countries. The wealthiest classes in Brazil, for example, are as wealthy as the wealthiest classes in France. The poor in Brazil are much poorer than the poor in France, but there is not much difference among the rich. And let's not forget that a young unskilled worker in East Baltimore has a life expectancy shorter than the average life expectancy in Bangladesh. There are classes in each country. And what has been happening in the world during the past 30 years is the forging of an alliance among the dominant classes of the North and South, an alliance that has promoted neoliberal policies that go against the interests of the dominated classes (the popular classes) of both North and South. There is an urgent need to develop similar alliances among the dominated classes of the North and South. As public health workers, we either can facilitate or obstruct the development of such alliances.

CLASS ALLIANCES AS DETERMINANTS OF NON-CHANGE

I became fully aware of this situation when I was advisor to the Unidad Popular government presided over by Dr. Salvador Allende in Chile. It was not the United States that imposed the fascist coup led by Pinochet (as was widely reported at the time). I was in Chile and could see what was happening. It was the *Chilean* economic, financial, and land-owning elites, the *Chilean* Church, the *Chilean* upper and upper-middle classes, and the *Chilean* army that rose up against the democratic government, in a fascist coup supported not by the United States (the United States is not a country of 244 million imperialists) but by the U.S. federal government, headed by the highly unpopular President Nixon (who had sent the U.S. Army to put down a general strike in the coal mining region of Appalachia). One should never confuse a country's people with its government. And this is particularly important in the United States: 82 percent of the population believes the government does not represent their interests, but rather the interests of the economic groups (in the United States called the *corporate class*) that dominate the behavior of the government.

I am aware of the frequently made argument that the average U.S. citizen benefits from the imperialist policies carried out by the U.S. federal government. Gasoline, for example, is relatively cheap in the United States (although increasingly less so). This, it is said, benefits the working class of the United States. But this argument ignores the heavy dependence of Americans on private transportation and the costs of this transportation for the popular classes, who would

greatly benefit from (and would much prefer, according to most polls) public transportation, which is virtually non-existent in much of the country. It is an alliance between the automobile industry and the oil and gasoline industry that is responsible for the failure to maintain and develop public transportation. There is a lack of awareness outside the United States that the American working class is the first victim of the U.S. economic and political system. The health sector is another example of this. No other working population faces the problems seen in the U.S. health sector. In 2006, 47 million Americans did not have any form of health benefits coverage. And people die because of this. Estimates of the number of preventable deaths vary from 18,000 per year (estimated by the conservative Institute of Medicine) to a more realistic level of more than 100,000 (calculated by Professor David Himmelstein of Harvard University). The number depends on how one defines “preventable deaths.” But even the conservative figure of 18,000 deaths per year is six times the number of people killed in the World Trade Center on 9/11. That event outraged people (as it should), but the deaths resulting from lack of health care seem to go unnoticed; these deaths are not reported on the front pages, or even on the back pages, of the *New York Times*, *Washington Post*, *Los Angeles Times*, or any other U.S. newspaper. These deaths are so much a part of our everyday reality that they are not news.

But besides the problem of the uninsured, the United States has another major problem: the underinsured. One hundred and eight million people had insufficient coverage in 2006. Many believe that because they have health insurance, they will never face the problem of being unable to pay their medical bills. They eventually find out the truth, however—that their insurance is dramatically insufficient. Even for families with the best health benefits coverage available, the benefits are much less comprehensive than those provided as entitlements in Canada and in most E.U. countries. Paying medical bills in the United States is a serious difficulty for many people. In fact, inability to pay medical bills is the primary cause of family bankruptcy, and most of these families have health insurance. Furthermore, 20 percent of families spend more than 10 percent of their disposable income on insurance premiums and medical bills (the percentage is even higher for those with individual insurance: 53 percent). In 2006, one of every four Americans lived in families that had problems with paying medical bills. Most of them had health insurance. And 42 percent of people with a terminal disease worry about how they or their families are going to pay their medical bills. None of the E.U. countries face this dramatic situation.

THE SITUATION IN DEVELOPING COUNTRIES

The class dominance and class alliances existing in the world today are at the root of the problem of poverty. These alliances reproduce the exploitation responsible for that poverty and for the underdevelopment of health. Let me quote from a respectable source. The *New York Times*, in a rare moment of candor, analyzed

poverty in Bangladesh, the “poorest country in the world.” But, Bangladesh is not poor. Quite to the contrary. It is a rich country. Yet the majority of its people are poor, with very poor health and quality of life. As the *New York Times* reported (5):

The root of the persistent malnutrition in the midst of relative plenty is the unequal distribution of land in Bangladesh. Few people are rich here by Western standards, but severe inequalities do exist and they are reflected in highly skewed land ownership. The wealthiest 16 percent of the rural population controls two-thirds of the land and almost 60 percent of the population holds less than one acre of property. . . . The new agricultural technologies being introduced have tended to favor large farmers, putting them in a better position to buy out their less fortunate neighbors. Nevertheless, with the government dominated by landowners—about 75 percent of the members of the Parliament hold land—no one foresees any official support for fundamental changes in the system. . . . Food aid officials in Bangladesh privately concede that only a fraction of the millions of tons of food aid sent to Bangladesh has reached the poor and hungry in the villages. The food is given to the government, which in turn sells it at subsidized prices to the military, the police, and the middle class inhabitants of the cities.

Finally, the *New York Times* concluded:

Bangladesh has enough land to provide an adequate diet for every man, woman and child in the country. The agricultural potential of this lush green land is such that even the inevitable population growth of the next 20 years could be fed easily by the resources of Bangladesh alone.

Let me repeat. It is not the North versus the South, it is not globalization, it is not the scarcity of resources—it is the power differentials between and among classes in these countries and their influence over the state that are at the root of the poverty problem. In most developing countries, the dominant landowning class, which is in alliance with the dominant classes of the developed countries, controls the organs of the state. And historical experience shows that when the landless masses revolt against this situation to force a change, the dominant classes, of both South and North, unite to oppose change by any means available, including brutal repression. This is the history of populations that try to break with their state of health underdevelopment. And we are witnessing now the hostility in the mainstream media of the United States and of the European Union against governments like the Chavez government in Venezuela or the Evo Morales government in Bolivia that carry out reforms that affect the economic interest of those class alliances.

THE FAILURE OF NEOLIBERALISM

Another assumption made in the neoliberal discourse is that the development of neoliberal policies has stimulated tremendous economic growth and improved populations' health and quality of life. Here again, the evidence contradicts this assumption. The average growth of real gross domestic product (GDP) per capita in Latin America was an impressive 82 percent during the period 1960–1980, but declined to 9 percent in the liberal period 1980–2000 and, further, to 1 percent in the period 2000–2005. This decline explains the rebellions against neoliberal policies when they were implemented in Latin America. Regarding health indicators, as Figure 1 shows, for countries with similar levels of development at the starting point of the study period (e.g., in 1980 having the same level of development that others have in 1960), there was a much lower level of improvement in infant mortality during 1980–2002 than during 1960–1980. A similar situation appears in developed countries. In the United States, there has been a large increase in mortality differentials and a steady deterioration in the health benefits coverage of the population. One million people have lost health benefits coverage every year in that country over the last ten years.

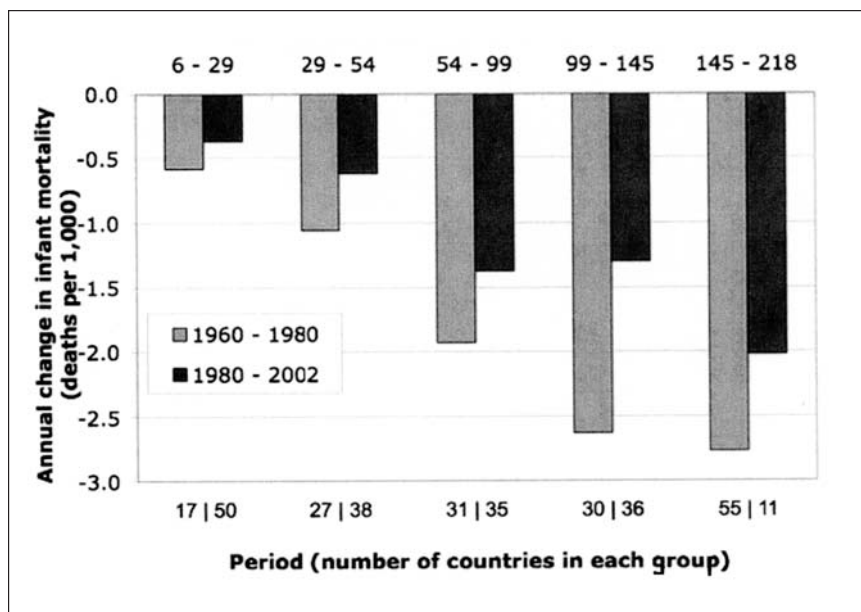


Figure 1. Infant mortality rate. *Source:* M. Weisbrot, D. Baker, and D. Rosnick. The scorecard on development: 25 years of diminished progress. *Int. J. Health Serv.* 36(2):211–234, 2006.

THE SOCIAL SITUATION IN EUROPE

Let's now look at what has been happening in the European Union—what has been happening in the labor market, unemployment, salaries, working conditions, social protections, social benefits, and business profits in the E.U. 15. We'll focus on the E.U. 15 here because these countries have been in the European Union for the longest time and thus exposed to E.U. policies for the longest periods.

Figure 2 shows how unemployment has increased in the E.U. 15 since the early 1970s, coinciding with the development of policies aimed at establishing the European Union. Notice that Europe had lower unemployment than the United States during the period 1960–1980, and much larger unemployment in the period 1980–2003.

In Figure 3 we see how labor compensation (which includes compensation for work, social protection of workers, contributions to retirement allowances, and self-employment), as a percentage of the national income in the E.U. 15, declined during the period 1975–2005. That reduction took place even though the number of workers increased. Moreover, it was independent of the economic cycle.

Figure 4 shows how intensity and stress at work increased in practically all E.U. 15 countries. On average, the percentage of workers living under pressure increased from 32 percent in 1991 to 45 percent in 2005. A consequence in the workplace is that work-related illness also increased.

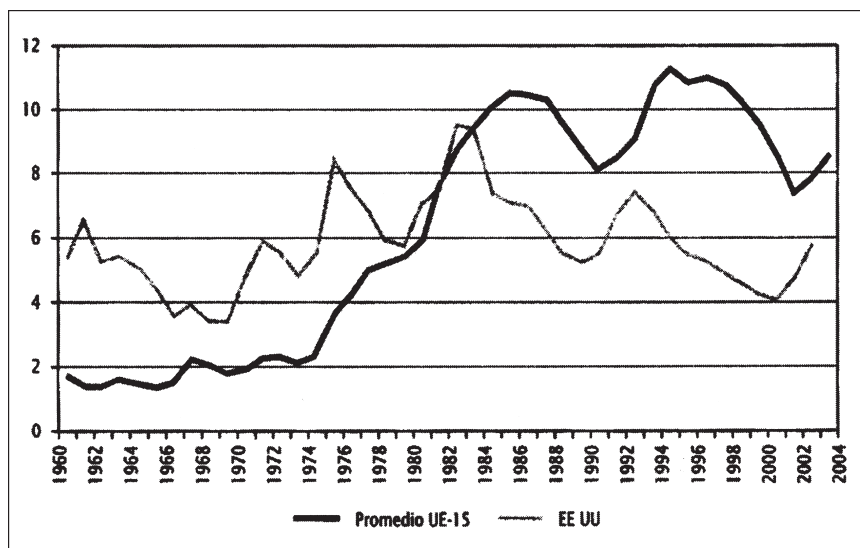


Figure 2. Unemployment. Evolution of unemployment (as percentage of population), average of the E.U. 15 (black, lower left to upper right) and United States (gray), 1960–2003. *Source:* Annual Macroeconomic Database (AMECO), European Commission.

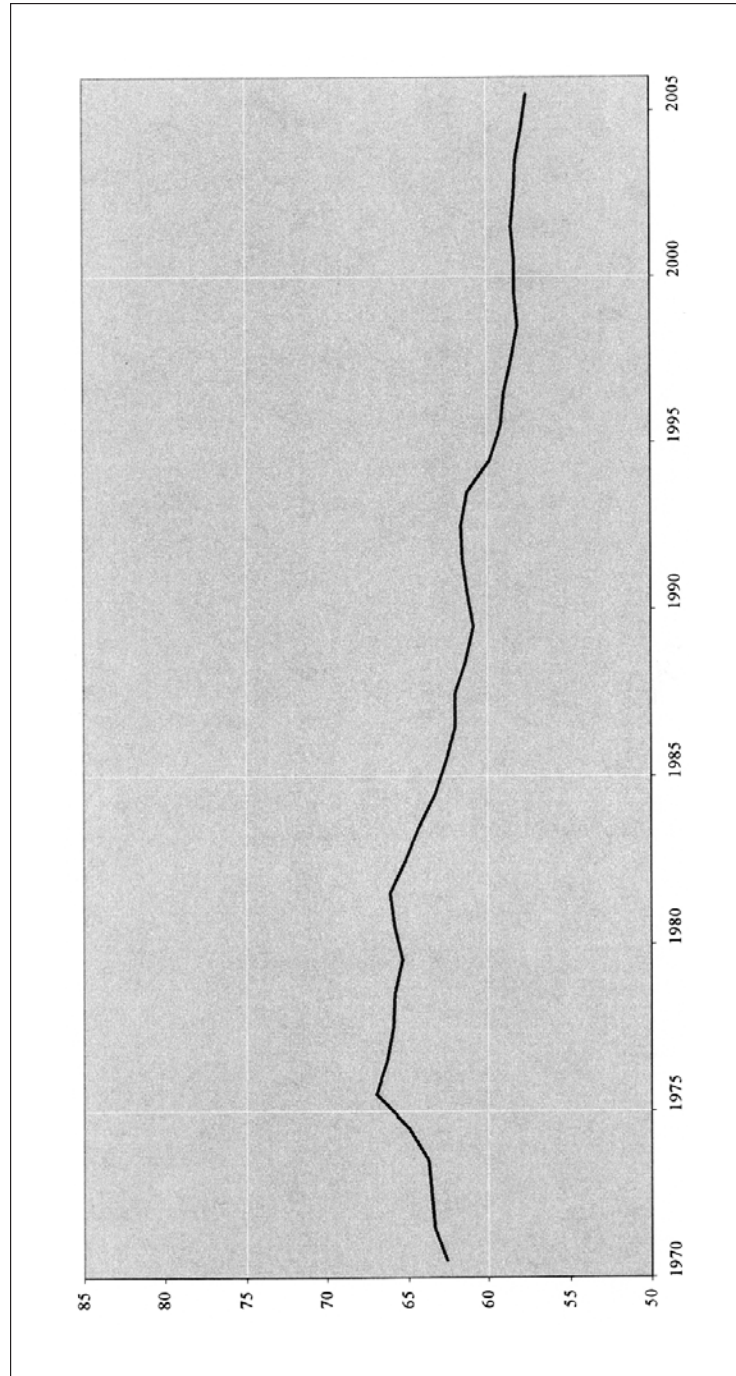


Figure 3. Salaries. Percentage of labor compensation in national income in E.U. 15, 1970–2005. Total compensation for work, including social protection of workers, contributions to retirement allowance, and self-employment. *Source:* OECD estimates, using OECD Economic Outlook database.

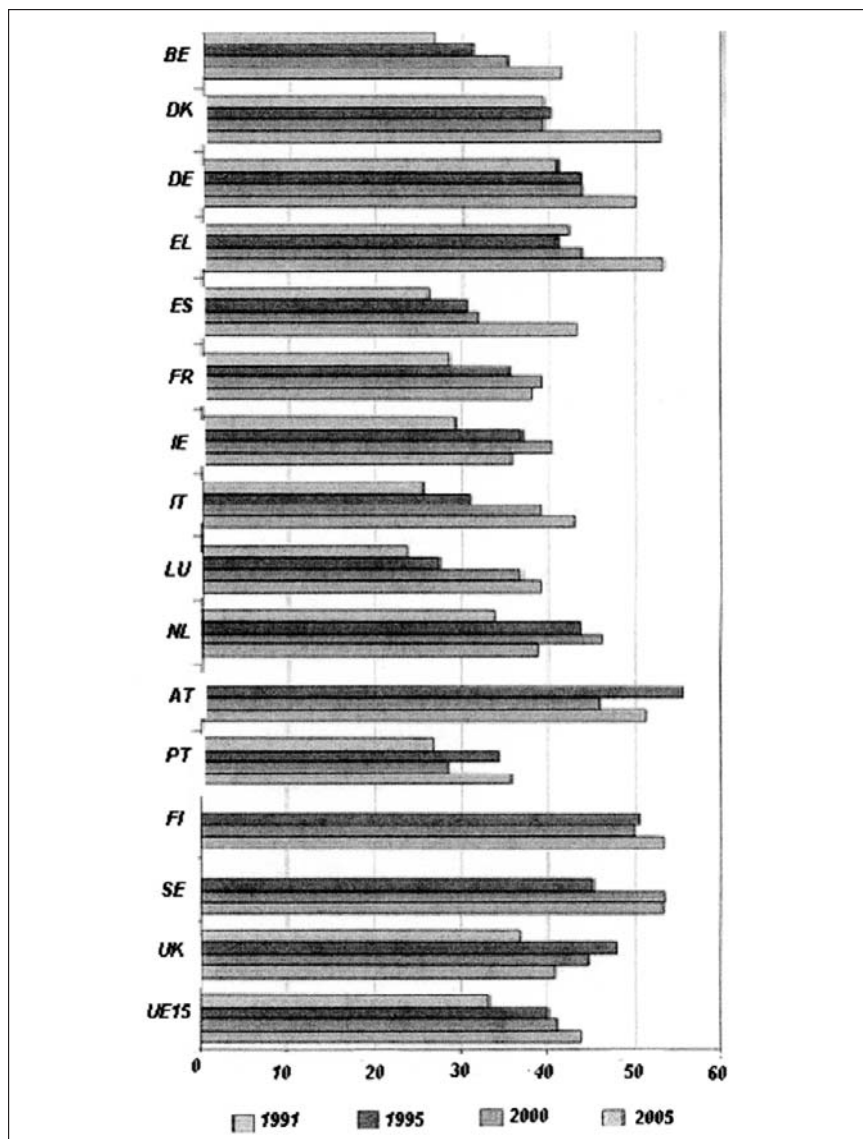


Figure 4. Work intensity. Evolution of work intensity (percentage of population working under stressful conditions), E.U. 15, 1991–2005. Countries, from top to bottom: Belgium, Denmark, Germany, Greece, Spain, France, Ireland, Italy, Luxembourg, Netherlands, Austria, Portugal, Finland, Sweden, United Kingdom, and E.U. 15. For each country, bars represent, from top to bottom, 1991, 1995, 2000, 2005. *Note:* 1991 data for Austria, Finland, and Sweden are not included, because they were not part of the European Union in 1991. *Source:* Eurofound.

The rate of growth of social public expenditures, as shown in Figure 5, also decreased during the period 1990–2004. And Table 1 shows how social benefits (sickness insurance compensation, occupational accident compensation, and unemployment insurance) declined in all countries during the period 1975–1995. The Anglo-Saxon liberal countries (Australia, Canada, United States, Ireland, New Zealand, and United Kingdom) saw the largest cuts in benefits, followed by the Christian democratic countries and the social democratic countries; the reduction was not linear, with some cuts more accentuated in some social democratic countries than in liberal countries. But, in all the E.U. 15 countries, social benefits declined.

As these figures and table show, the conditions of work and of social benefits coverage for the working class and other sectors of the popular classes have deteriorated, in stark contrast to the exuberant profits enjoyed by the employer class. From 1999 to 2006, profits increased 33.2 percent in the E.U. 15 and 36.6 percent in the Eurozone. Labor costs, however, increased only 18.2 percent.

In summary, then, during the years of establishing the E.U. 15, there were increased capital incomes, decreased workers' incomes, increased salary inequalities, increased fiscal regressivity, decreased social benefits, and decreased social protections—all resulting in an increase in social inequalities. And this has been accompanied by an increased percentage of the population that considers the income inequalities excessive (78%, the largest percentage since World War II). It is also worth noting that a growing number of people in the working and popular classes believe that the deterioration of their social situation is due to the public policies developed as a consequence of establishment of the European Union. Are they right in their beliefs?

WHAT EXPLAINS THE ANTI-EUROPEAN MOOD AMONG EUROPE'S WORKING CLASSES?

To answer this question, we must first look at the reasons given by the European establishment—the *Brussels consensus*—for the growth of unemployment in the E.U. 15. The E.U. establishment has attributed the increased unemployment to three factors: (a) excessive regulation of the labor markets, (b) excessive generosity of social benefits, and (c) excessive public expenditures. Consequently, the E.U. establishment has: (a) deregulated labor markets; (b) restrained and/or reduced public expenditures—an example, among many others, is the declaration by Pedro Solbes, for many years the commissioner of Economic and Monetary Affairs of the E.U. 15, now Minister of Economy of the socialist government in Spain, that “the policy that I am most proud of is not to have increased public expenditures in Spain,” a declaration made in the country with the lowest public expenditures (after Poland) in the E.U. 15; and (c) reduced social benefits, which has reached its maximum expression in the proposal to increase the allowable working time to more than 65 hours per week.

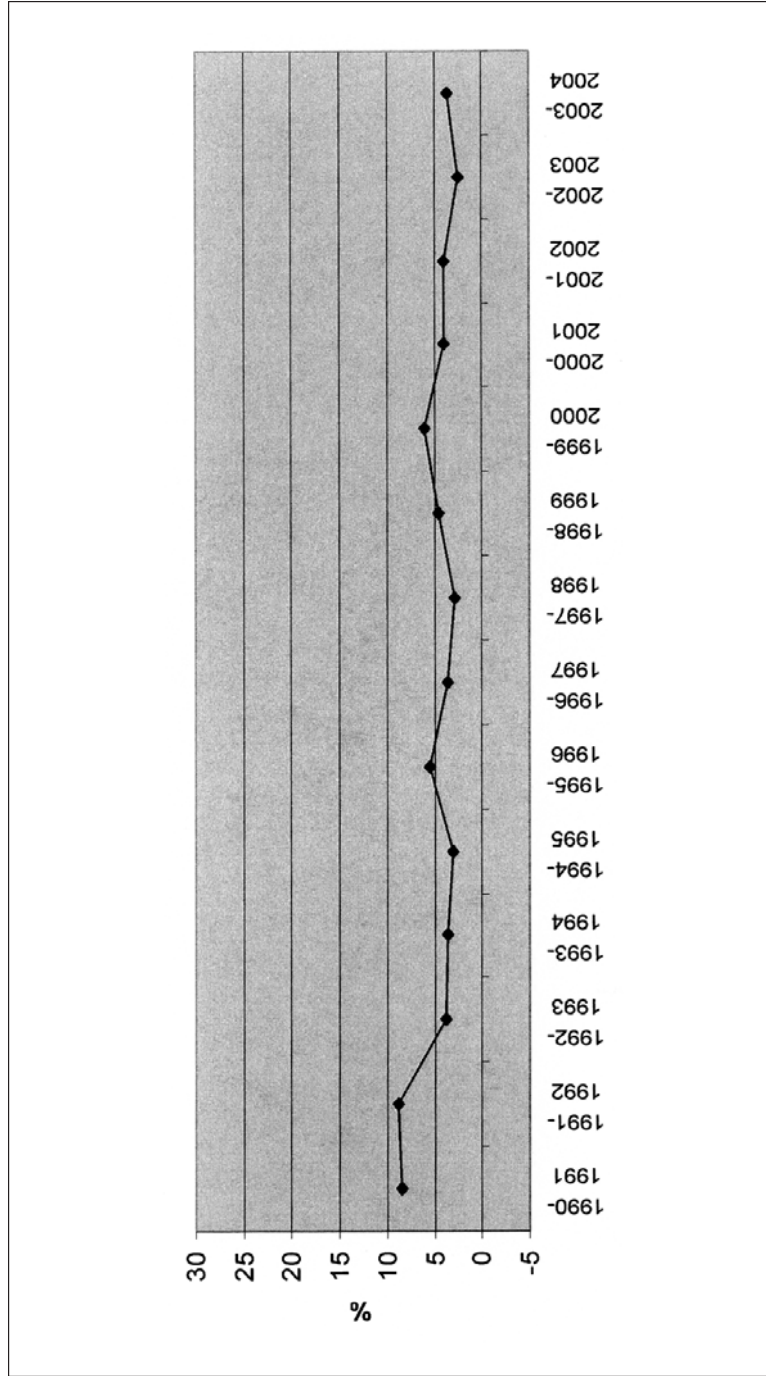


Figure 5. Social protection. Decrease of the rate of change (percent) in public social expenditure per capita, E.U. 15, 1990-2004. Source: Eurostat (online access July 25, 2007).

Table 1
 Social benefits: substitution rates in sickness insurance, occupational accident, and unemployment, and percentage reduction of substitution rates during 1975–1995 (five-year periods)—data for 16 countries, classified by political tradition

Political tradition	Country	Sickness			Occupational accident			Unemployment		
		Level	Reduction	Reduction	Level	Reduction	Reduction	Level	Reduction	
Liberal	Australia	48.4	-10.1 ^a	—	—	—	—	48.4	-10.1 ^a	
	Canada	62.9	-15.4 ^a	—	—	—	72.7	-13.1 ^a		
	USA	—	—	—	—	—	59.8	-12.8 ^a		
	Ireland	56.3	-33.5 ^c	64	-31.5 ^c	56.3	-34.9 ^c			
	New Zealand	57.5	-34.7 ^c	94.3	-16 ^a	57.5	-25 ^a			
	United Kingdom	63.4	-43.1 ^a	71.6	-51.3 ^a	63.4	-39.9 ^a			
Christian democratic	Germany	100	0	100	0	74.3	-6.4 ^d			
	Austria	99.2	-4.6 ^c	100	-3.4 ^c	47.4	-10.1 ^c			
	Belgium	91.9	-0.3 ^a	100	-3.7 ^a	76	-28.1 ^b			
	France	55.7	-6.8 ^a	66.8	0	41.1	-7.2 ^c			
	Italy	68.1	0	74.1	0	66.8	-23.8 ^b			
	Netherlands	84.7	-14.7 ^b	84.7	-14.7 ^b	81.6	-13.2 ^b			
Social democratic	Denmark	74.7	-21.4 ^b	74.7	-21.4 ^b	81.9	-24.5 ^a			
	Finland	86.1	-10.3 ^d	100	0	59.1	-5 ^d			
	Norway	55	0	55	0	73.5	-10 ^a			
	Sweden	90.3	-13.8 ^c	92.6	-21.8 ^c	77.1	-7.3 ^d			

Source: W. Korpi and J. Palme. New politics and class politics in the context of austerity and globalization: Welfare state regress in 18 countries, 1975–95. *American Political Science Review* 97(3):425–446, 2003.

Note: Years of last maximum: a = 1975, b = 1980, c = 1985, d = 1990.

These policies have been instituted within the framework of the monetary policies established in the Stability Pact, which requires austerity in public expenditures, and the European Central Bank policies of prioritizing the control of inflation over economic growth and job creation. In the United Kingdom (the first country that developed those policies, under Thatcher), a consequence of these policies has been a slowing down of the rate of mortality decline for all age groups, as shown in Figure 6.

COMPONENTS OF A NATIONAL HEALTH PROGRAM: WHAT SHOULD IT CONTAIN?

Clearly, the traditional responses of medical care institutions to all of these realities are completely insufficient. Medical care does indeed provide more care than cure. The major causes of mortality—cancer and cardiovascular diseases—will not be solved through medical interventions. Medical institutions take care of individuals with these conditions and improve their quality of life, but they do not resolve these (or most other) chronic problems. Disease prevention and health promotion programs primarily based on behavioral and lifestyle interventions are also insufficient. We have plenty of evidence that programs aimed at changing individual behavior have limited effectiveness. And understandably so. Instead, we need to broaden health strategies to include political, economic, social, and cultural interventions that touch on the *social* (as distinct from the *individual*) determinants of health. These interventions should have the empowerment of people as their first objective. Thus, a national health policy should focus on the structural determinants of health and should have as its primary components political, economic, social, and cultural health policy interventions, focusing on (a) public policy to encourage participation and influence in society, (b) economic and social determinants, (c) cultural determinants, (d) working life interventions, (e) environmental and consumer protection interventions, (f) secure and favorable conditions during childhood and adolescence and during retirement, and (g) health care interventions that promote health.

Let me stress that empowering people is of paramount importance. We are witnessing on both sides of the Atlantic, in the United States and in the European Union, a crisis of democracy. The representative institutions are widely perceived as controlled and instrumentalized by the dominant economic and financial groups in society. In the United States, confidence in the political establishment (referred to as “Washington”), perceived as captive to the corporate class, is at an all-time low. All political candidates in the 2008 presidential primaries, even John McCain, presented themselves as anti-Washington. A similar situation is occurring in the E.U. 15, where in country after country the working classes are clearly rejecting the European project that has been constructed by economic and financial groups with a minimum of democratic participation. It is not just that France, the Netherlands, and Ireland have rejected the European Constitution, but

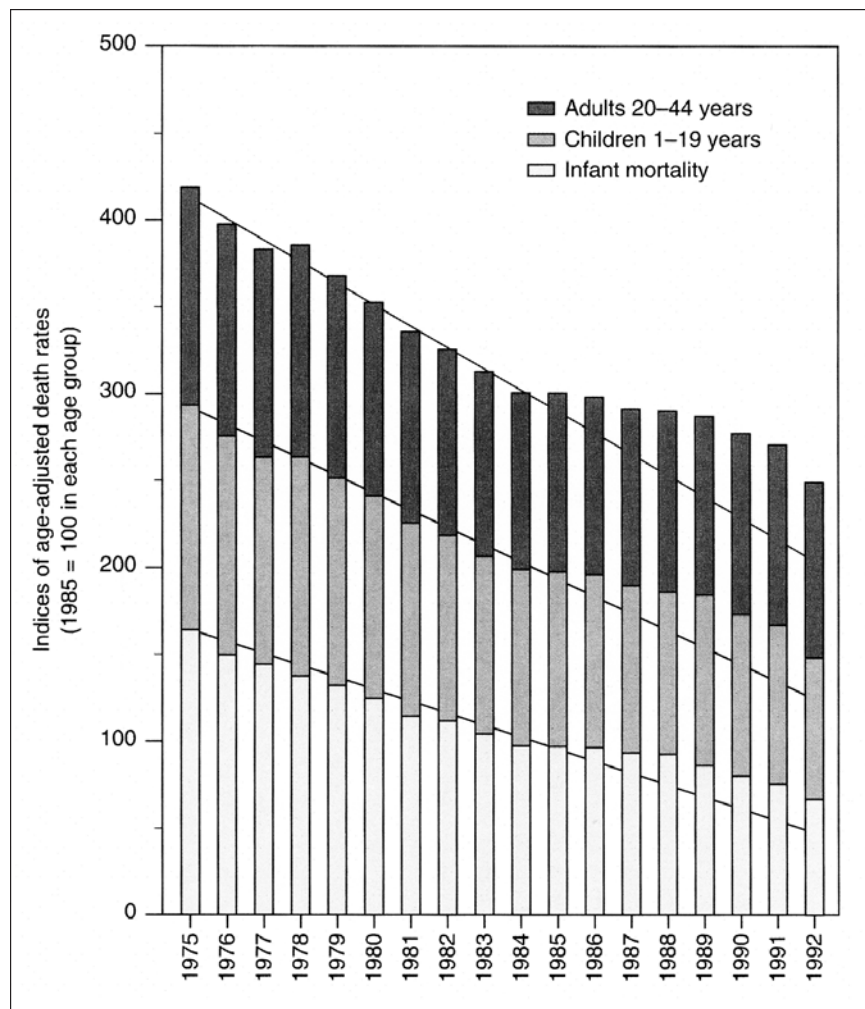


Figure 6. Indices showing changes in death rates among young adults, children, and infants (male and female combined), England and Wales, 1975-1992. Source: R. G. Wilkinson, *Unhealthy Societies*, Figure 5.10, Routledge, 1996.

polls also show that the working classes of Denmark, Sweden, Germany, and many other countries are against the Constitution. An extremely important and urgent public health project is to recover the representativeness of political institutions and make them accountable to the large sectors of the population that have been disenfranchised—which leads me, finally, to my critique of the WHO Commission’s report.

As I mentioned at the beginning of this talk, I saluted the establishment of the WHO Commission on the Social Determinants of Health and welcome its analysis and recommendations. As a matter of fact, I wish the Commission could receive the Nobel Prize in Medicine, or the Peace Prize, for its work. It has produced a solid, rigorous, and courageous report, and it goes a long way in denouncing the social constraints on the development of health. The report's phrase "social inequalities kill" has outraged conservative and liberal forces, which find the narrative and discourse of the report too strong to stomach.

And yet, this is where the report falls short. It is not *inequalities* that kill, but *those who benefit from the inequalities* that kill. The Commission's studious avoidance of the category of power (class power, as well as gender, race, and national power) and how power is produced and reproduced in political institutions is the greatest weakness of the report. It reproduces a widely held practice in international agencies that speaks of policies without touching on politics. It does emphasize, in generic terms, the need to redistribute resources, but it is silent on the topic of whose resources, and how and through what instruments. *It is profoundly apolitical, and therein lies the weakness of the report.*

My comments here, I should note, are not so much a critique of the Commission's report as a criticism of the WHO—and other such international agencies, for that matter. These agencies always have to reach a consensus, and consensus always gives the most powerful the power of veto. Any conclusion or subject or terminology that may offend the powerful groups seated at the table, who have to approve the report, must be dropped. The Commission's report goes very far in describing how inequalities are killing people. But we know the names of the killers. We know about the killing, the process by which it occurs, and the agents responsible. And we, as public health workers, must denounce not only the process, but the forces that do the killing. The WHO will never do that. But as public health workers we can and must do so. It is not enough to define disease as the absence of health. Disease is a social and political category imposed on people within an enormously repressive social and economic capitalist system, one that forces disease and death on the world's people.

Recall that it was Chadwick, one of the founders of public health, who, as Commissioner of the Board of Health of Great Britain in 1848–1854, declared that the poorer classes of that country were subject to steady, increasing, and sure causes of death: "The result [of the social situation] is the same as if twenty or thirty thousand of these people were annually taken out of their wretched dwelling and put to death." A century and a half later, millions of people, in both the North and the South, are put to death in just this way. And we know the economic, financial, and political forces responsible for this. And we have to denounce them by name.

It was Engels who, in his excellent public health work on the conditions of the British working class, showed the incompatibility between the capitalist economic system and the health and working conditions of working people. And

it was Virchow who, in response to the outraged dismissal, as too political, of his recommendations to improve the population's health—by redistributing the land, water, and property of Germany—by the city fathers (the owners of the land, water, and property), responded: “Medicine is a social science and politics is nothing more than medicine on a large scale” (6). What we, as public health workers, need to do is to act as agents, including political agents, for change. I hope you agree.

Thank you very much for your attention.

Note — This keynote address was given at the Eighth IUHPE European Conference on September 9, 2008, in Turin, Italy, and was originally published in IUHPE – *Global Health Promotion*, Vol. 16, No. 1, 2009, SAGE Publications.

REFERENCES

1. Navarro, V. Race or class versus race and class: Mortality differentials in the U.S. *Lancet* 336:1238–1240, 1990.
2. Navarro, V. Assessment of the World Health Organization Report 2000. *Lancet* 356:1598–1601, 2000.
3. Navarro, V. World Health Report 2000: Responses to Murray and Frenk. *Lancet* 357:1701–1702; discussion, 1702–1703, 2001.
4. Williamson, J. *What Washington Means by Policy Reform*. Institute for International Economics, Washington, DC, 1990.
5. *New York Times*, September 12, 1992.
6. Virchow, R. Die medizinische Reform, 2. In H. E. Sigerist, *Medicine and Human Welfare*, 93, 1941.

Direct reprint requests to:

Vicente Navarro
Department of Health Policy and Management
Johns Hopkins University Bloomberg School of Public Health
624 North Broadway, Room 448
Baltimore, MD 21205

e-mail: vnavarro@jhsph.edu