

## History of the social determinants of health

The vast amount of literature produced over the past few years on SDH makes one think that this is a new area of scholarship. However, the recognition that **social factors have an important impact on people's health is long-standing but written documentation starts only from the 19<sup>th</sup> century sanitary campaigns in Europe**. Renewed interest in the SDH - best illustrated by the WHO's Commission on the Social Determinants of Health (CSDH) - represents yet another cycle of recognition of the importance of structural determinants of health that began in the early 1800 with the writing of Virchow, Engels and, later on McKeown, to name just a few.

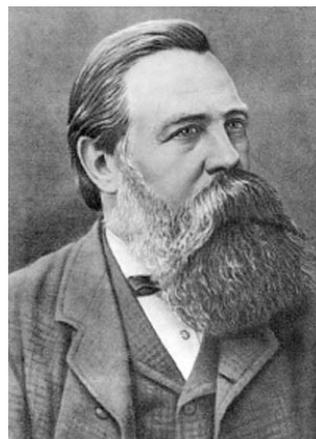
### Founding fathers

In the mid-1800, Virchow and Engels made the explicit link between living conditions and health but also explored the political and economic structures that create inequalities in the living conditions which lead to health inequalities. Later, in 1955, McKeown argued that the population growth in the UK post-1700 was due to economic conditions rather than improved medicine and public health.

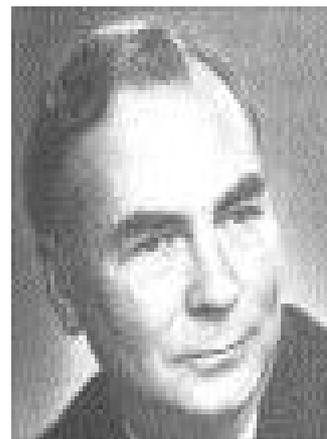
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**Rudolf Virchow**



**Friedrich Engels**



**Thomas McKeown**

Much of the work of the "founding fathers" of modern public health reflected awareness of the powerful relationship between people's social position, their living conditions and their health outcomes.

**Please click the link below to study about institutional history of the SDH**

[Institutional History](#)

## Recent developments

**The Commission on Social Determinants of Health (CSDH) was established by WHO in 2005 to support countries and global health partners in addressing the social factors leading to ill health and health inequities.**

The Commission aimed to **draw the attention of governments and society to the SDH and in creating better social conditions for health, particularly among the most vulnerable people**. The commission delivered its report to the World Health Organisation in July 2008 and we will discuss later during the course the suggestion. The work of the Commission demonstrated that health inequities are the result of a complex system operating at global, national and local levels.

**Commission was led by Professor Michael Marmot** who has led a research group on health inequalities for the past 30 years at the University College, London. He is Principal Investigator of the Whitehall Studies of British civil servants, investigating explanations for the striking inverse social gradient in morbidity and mortality which you can read about in the institutional history of the SDH section. In 2000 he was knighted by Her Majesty The Queen for services to Epidemiology and understanding health inequalities.



Additional reading: [What is our focus?](#) (Sir Michael Marmot, WHO)



## Rudolf Virchow

*"Do we not always find the diseases of the populace traceable to defects in society?"*

Rudolf Virchow (1821 –1902) was a German scientist credited with multiple important discoveries and his approach encompassed biology, anthropology and politics:

- [ He pioneered the **modern concept of pathological processes** by his application of the cell theory to explain the effects of disease in the organs and tissues of the body. He emphasized that diseases arose, not in organs or tissues in general, but primarily in their individual cells. Therefore, he is referred to as "**the father of modern pathology**".
- [ However, Ignaz Semmelweis' theory that puerperal fever resulted from an infectious cause was in direct contradiction to Virchow's cell concepts. Virchow's rejection of the theory that bacteria caused the disease delayed the use of antiseptics in the 1860's.
- [ Virchow is also considered **one of the founders of social medicine known for his advancement of public health**. Virchow was an impassioned advocate for social and political reform.
- [ A notable and important statement made by Virchow is: *Medicine is a social science, and politics is nothing else but medicine on a large scale. Medicine, as a social science, as the science of human beings, has the obligation to point out problems and to attempt their theoretical solution; the politician, the practical anthropologist, must find their means for their actual solution ... The physicians are the natural attorneys of the poor, and social problems fall to a large extent within their jurisdiction.*

### Read more about Rudolf Wirchow:

Navarro V (2008): Politics and health: a neglected area of research, European Journal of Public Health, Vol. 18, No. 4, 354–356.

Brown, T, Fee, E (2006): Report on the Typhus Epidemic in Upper Silesia, American Journal of Public Health, Vol 96, No. 12.

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## Friedrich Engels

In 1845, in **The Condition of the Working Class in England**, which was his first book, Engels asked, *How is it possible for the lower class to be healthy and long-lived? What else can be expected than an excessive mortality, an unbroken series of epidemics, a progressive deterioration in the physique of the working population?*

The analysis is based on observations with the working class in Manchester. Engels argued that the Industrial Revolution made workers worse off. He showed that in **industrial cities mortality from disease, as well as death-rates for workers were way much higher than in the countryside**. In cities like Manchester and Liverpool mortality from measles, smallpox, scarlet fever and whooping cough was four times high as in the surrounding countryside and mortality from convulsions was ten times as high.

According to Birn (2009), the WHO 2008 statement that *Social injustice is killing people on a grand scale* is a less impolite formulation of Friedrich Engels's concept of social murder. Engels wrote: *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.*

Not only was Engels arguing that social injustice was killing on a grand scale, he identified the perpetrators: the English aristocracy and bourgeoisie in Victorian England.

Often times Friedrich Engels is looked upon as the founding father of social medicine whose analysis of the living conditions of the English working class started line of research that is currently known as the SDH. He showed how the health of deprived workers and their children were affected by extremely adverse living and working conditions. Later on, epidemiological research has confirmed the importance of social, economic and environmental factors in the major population health improvements in industrialized countries since the early 19th century.

### Read more about Friedrich Engels:

Birn, A (2009): Making it Politic(al): Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health, Social Medicine, Vol 4, Num 3, 166-182.

Engels, F (1993, originally 1845 in German, 1887 in English): The Condition of the Working Class in England, with an introduction by McLellan David, Oxford University Press, 1993.

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**Thomas McKeown**

Thomas McKeown was a rhetorically powerful critic, from the inside, of the medical profession's mid-20th-century appreciation of curative and scientific medicine. He ran a project to investigate the historical demography of 18th-century Britain and the historical epidemiology of Victorian Britain.

Originally published in 1976, Professor Thomas McKeown's influential book "*The role of medicine – dream, mirage or nemesis?*" put forward a formidable and convincing argument to the effect that health care itself made only a minor contribution to the massive improvements in population health between the mid-nineteenth and mid-twentieth century in the developed world

McKeown's argument was based on the fact that between roughly 1850 and 1970, the greatest decreases in mortality and advances in life expectancy for particular diseases occurred before the introduction of improved medical treatments for those conditions. McKeown argued that these advances were actually the result of better nutrition associated with rising living standards. He even rejected any significant role for public health measures such as improved hygiene and sanitation, again because they only became effective after the decline in mortality was well underway.

At the time of their first publication, McKeown's theories flew in the face of accepted wisdom which saw scientific advance and better medicine as the principal drivers of better health. His controversial hypothesis helped revolutionise how the health of populations was viewed.

**Read more about Thomas McKeown:**

Bynum, B (2008): The art of medicine - The McKeown thesis, *Lancet* Vol 371, 644-645.

Szreter, Simon (2002): Rethinking McKeown – The relationship between public health and social change, *American Journal of Public Health*, vol 92, no 5, 722-725.

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## Institutional history

In the institutional arena, the Constitution of the World Health Organization, drafted in 1946, shows that **the Organization's founders intended for WHO to address the social roots of health problems, as well as the challenges of delivering medical care.** The constitution ambitiously defines health as a state of complete physical, mental and social well-being, identifying the Organization's goal as "the attainment by all peoples of the highest possible level" of this state.

Next major milestone in the broad field of SDH was the Alma **Ata Declaration** in 1978. The declaration was output of the International Conference on Primary Health Care was held in Alma Ata, USSR (now Almaty, Kazakhstan). The conference was co-sponsored by the WHO. It was considered groundbreaking because it linked the rights-based approach to health and primary health care as a strategy for attaining it. It was the first international declaration stating the importance of primary health care for reducing health inequalities between and within countries. It also outlined the world governments' role and responsibilities to the health of the world's citizens. By doing so, it identified primary health care as the key to the attainment of the goal of Health for All.



The direct roots of contemporary efforts to identify and address socially-determined health inequalities reach back to [the Canadian Lalonde Report \(1974\)](#) and [the Black Report in the UK \(1980\)](#).

In 1986, the first International Conference on Health Promotion was held in Ottawa, Canada as a follow-up to Alma-Ata. The aim of the conference was to continue to identify action to achieve the objectives of the World Health Organization (WHO) Health for all by the year 2000 initiative, launched in 1981. It was followed by a series of international health promotion conferences. The **Ottawa Charter** promotes social justice as it is designed to provide access to health opportunities for all community members and aims to reduce the level of health inequalities. The 5 key action areas of the Charter reflect public health approach with a strong emphasis on social justice issues.

The WHO [Commission on the Social Determinants of Health \(CSDH\)](#) confirmed previous reports of health inequities between nations as well as "health gradients" within nations. It again pointed out that the poor are worse off than those less deprived, the less deprived

are worse off than those with average incomes, and so on, up the social hierarchy. It confirmed that this health gradient exists in all nations, including the richest. It also confirmed that health equality cannot be achieved by medical systems alone.

The renowned quote from the Commission states *what good does it do to treat people's illnesses and send them back to the same conditions that made them sick.*

According to Berkman and Sivakramkrishnan, the commission on social determinants of health has done what few reports do – that is to open dialogue between scientists and policymakers to pave the way for introducing evidence into the politics and pathways of policymaking.

CSDH represents an important milestone because it again called for action to achieve greater health equity by focusing attention on the central role of the social determinants and by collation of global evidence to support this action. [Nine knowledge networks, established to aid the CSDH, have been synthesizing knowledge on opportunities for improved action in key areas](#)

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**The Lalonde Report** is a 1974 report produced in Canada formally titled A new perspective on the health of Canadians. It proposed the concept of the "health field", identifying two main health-related objectives: the health care system, and prevention of health problems and promotion of good health.

The report is considered the "first modern government document in the Western world to acknowledge that our emphasis upon a biomedical health care system is wrong, and that we need to look beyond the traditional health care (sick care) system if we wish to improve the health of the public.

**The Black report** is a report of the expert committee into health inequality published in 1980 by the UK Department of Health and Social Security (the Department of Health now). The committee was chaired by Sir Douglas Black.

The report demonstrated that although overall health had improved since the introduction of the welfare state, there were widespread health inequalities. It also found that the main cause of these inequalities was economic inequality. The report showed that the death rate for men in social class V was twice that for men in social class I and that gap between the two was increasing, not reducing as was expected.

The study had little immediate policy impact in the UK, then governed by Prime Minister Margaret Thatcher's Conservative Party, whose leadership dismissed the recommendations as utopian. However, the document generated strong interest in portions of the scientific community. It inspired a number of comparable national enquiries into health inequalities in countries such as the Netherlands, Spain and Sweden. Public health specialists and political leaders in several countries began to explore policy options to address the troubling patterns the studies revealed – though action remained vulnerable to political power shifts (e.g., in Spain).

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**The Commission of Social Determinants of Health (CSDH)** was established by WHO in March 2005 to support countries and global health partners in addressing the social factors leading to ill health and health inequities.

The commission aimed to draw the attention of governments and society to the social determinants of health and in creating better social conditions for health, particularly among the most vulnerable people. The ultimate aim of the Commission was to leverage policy change by turning existing public health knowledge into actionable global and national policy agendas.

The Commission delivered its report to the World Health Organisation in July 2008 and it subsequently ended its functions.

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**Nine knowledge networks, established to aid the CSDH,** have been synthesizing knowledge on opportunities for improved action in key areas:

1. early child development and education,
2. employment and working conditions,
3. health care and health systems,
4. urban settings,
5. globalisation,
6. social exclusion,
7. women and gender equity,
8. priority public-health conditions,
9. and measurement and evidence.

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