Social Determinants in a Post-Conflict Colombia

An attractive proposition? Taking a social determinants approach to planning for a “new” peaceful society? How could it not be attractive. We have been arguing that health and health inequities tell us how we are doing as a society. It follows that planning for a new society should have social determinants of health at its heart. Hence the invitation to come to Colombia and be part of that discussion was irresistible.

There was a second reason I had to go to Bogota, and it relates to our social movement. We, IHE colleagues Jessica Allen, Ruth Bell and I, conducted a workshop for the Inter Academy Medical Panel on social determinants of health in Trieste Italy in summer of 2014. I said at the end of the workshop that there were senior representatives of Academies of Medical Science from 22 countries represented here; if only two of them went home and got active on social determinants of health I would consider the workshop a success; if three... a bonus; any more ... I would be in heaven.

So far we seem to have three: South Africa, Morocco, and Colombia, with Tanzania in the wings. Prof Luis Alejandro Barrera Avellaneda of Pontificia Universidad Javeriana in Bogota, who had been at the workshop, said that they were planning for a post-conflict Colombia, would I come and address their new inter-sectoral commission on public health, meet ministers, have an exchange with some of their university professors, and participate in a day-long conference on social determinants of health.

He, and Professor Francisco Jose Yepes Lujan, co-hosted my visit with generous hospitality.Significantly, the Minister of Health was present at the dinner at which the University rector presided. It suggests a good channel of communication.I found the Minister open, engaging and willing to discuss social determinants of health. Some of the Twitter commentariat suggested otherwise. I do not know what that is about.

Post-conflict Colombia? Any outsider who claims to understand Colombia’s recent history is not concentrating. People were born liberal or conservative, or socially excluded. In Britain these partisan differences are debated with childish insults, in Colombia with deadly weapons. A civil war in the late 1940s that led to a military dictatorship was followed, in 1957, by sixteen years of Liberals and Conservatives agreeing to take it in turn to lead the government. It was something that could not last. And indeed it did not. Marxist guerrillas, private armies of the right (the paramilitaries), the infamous drug cartels with their own armies – it is hard to keep track of all the violence. Arguably, with political assassinations
and kidnapping, the cartels overreached themselves, and were smashed. There is still a drug trade in cocaine – it partly funds the guerrillas. But the drug-related violence between rival gangs seems to have moved to Mexico.

Emerging from all of this violence, the government is in the process of signing an agreement with FARC the leading rebel group. It is a fragile peace, watched with suspicion by many. More than 200,000 people, mostly civilians, have been killed in the fighting, and 7 million people, out of a population of 48 million, have registered with the government’s victims unit as having been internally displaced by the violence, or kidnapped, injured or otherwise affected. Whew! How to row back from such pain.

I made a presentation to the Intersectoral commission on health, chaired by the minister of health and with representation from 9 ministries. As background to our discussions I had been sent an excellent report documenting health and their approach to social determinants of health in Colombia (see link below). We will, of course, have to see what happens but the existence of this intersectoral group led by ministers who in their speeches show a keen understanding that key determinants of health lie outside the health care system is hugely encouraging.

The next day, the conference itself at Javeriana University was hugely oversubscribed. I took this great level of interest as an expression that our social movement on social determinants is alive and well. The Minister of Health followed the University Rector (President) in opening the conference. I have notionally shared platforms with Ministers of Health in many countries. But the ministers almost always – Sweden was an exception – make their speech, and leave before any of the substantive presentations. I don’t take it personally (perhaps I should?). Here the Minister stayed and personally made commitments to me to send me examples of their cross-sectoral action.

A lively discussion included a challenge from the left. Have we any examples, I was asked, of successful action to diminish health inequities. Presumably not, because the problem is capitalism, which inevitably increases inequalities, and there is nothing that can be done. It is a point of view we had heard while conducting the Commission on Social Determinants of Health. Nothing that can be done? All of our recommendations useless? To me, it is a counsel of despair.

I had four responses to this challenge. First, I am arguing that social determinants implies addressing the causes of the causes. My interlocutor wants to address the political causes of the causes of the causes. Go for it. Do it, by all means. I wish him luck.

Second, the country with the best health in the world, and relatively narrow health inequalities, is Japan, a successful capitalist country; followed by the Nordic countries, also successful capitalist countries. In fact all the countries with the best health are capitalist countries. The question is not whether we want to reconstruct a better version of the Soviet Union or North Korea, but how, as Thomas Piketty argues in his Capital in the Twenty first Century, to construct capitalist societies that are fairer, more just, and less unequal.

Third, it is not true that the evidence shows that until we smash capitalism we can not make progress. There are two ways to gauge success: health of the most disadvantaged, and the health gradient. There are examples from all over the world of the health of the most disadvantage improving – a major societal success. But, in many countries they have not
been improving as rapidly as the better off. It remains a major challenge to address the social gradient in health. That is why we are in business.

Fourth, there are examples of reducing the slope of the health gradient, from Peru, Brazil, Bangladesh. It is simply not true that we cannot make progress on addressing the causes of the causes, without removing capitalism. That said, as we argued in the CSDH, commitment from the top of government is vital in addition to mobilisation of social movements from society.

In Colombia, itself, there has been considerable progress in reducing poverty, but poverty is still at very high level with strikingly high levels of inequality. There is much to be done. An intersectoral commission to improve health inequity is an important step in building a post-conflict Colombia.