

Social determinants of health: the “social” in question¹

Determinantes sociais da saúde: o “social” em questão

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¹ This article formed part of the Matser's dissertation by Júlia Garbois "Para crítica ao campo dos determinantes sociais da saúde", defended April 2014, Postgraduate Program in Public Health, UFES.

Abstract

This article seeks to discuss the vision of the 'social' in the field called social determinants of health. For this, bibliographical research was conducted, based on references from the field of human sciences, by authors such as Latour (2012) and Santos (1988). It begins with a general characterization of the field of social determinants of health, especially political and scientific views. Then, it presents the critical elements characterizing paths on the thinking of these authors. The study sought to highlight reductionism increasingly present in the approach to the field of social determinants of health. These reductionisms that ultimately limit further reading about the complexity of life in society and reinforce the commodification and trivialization of life. Santos (1988) notes that, in front of these reductionism, science cannot be merely producing a scientific paradigm, but also a social paradigm - the paradigm of a decent life. The thinking of Latour (2012) brought arguments to rethink the 'social' beyond a specific and limited domain of reality, as something always external to the subject and to their own health. The fragmented view of the field of social determinants of health is what we put into analysis and make inquiries as a way to raise future discussions on the topic.

Keywords: Social Inequity; Health Inequalities; Social Sciences; Public Health.

Resumo

Este artigo problematiza a visão sobre o “social” que subjaz a noção de determinantes sociais da saúde. Para isso, realizou-se um estudo exploratório, a partir de pesquisa bibliográfica em referenciais produzidos pelas ciências humanas, por meio de autores da sociologia contemporânea que refletem de forma crítica sobre como a ciência atual considera o “social”. O artigo inicia-se com uma caracterização geral do campo dos determinantes sociais da saúde, especialmente do ponto de vista político-científico. Logo em seguida, apresentam-se os elementos críticos, caracterizando caminhos sobre o pensamento dos autores supracitados. O estudo procurou destacar os reducionismos cada vez mais presentes na abordagem ao social no campo dos determinantes sociais da saúde. Tais reducionismos acabam por limitar uma leitura mais aprofundada sobre a complexidade da vida em sociedade e reforçam a mercantilização e banalização da vida. Santos (1988) observa que, frente a esses reducionismos, a ciência não pode ser somente a produção de um paradigma científico, mas um paradigma social - o paradigma de uma vida decente. O pensamento de Latour (2012) trouxe argumentos para repensar o “social” para além de um domínio específico e limitado da realidade, como algo sempre externo ao sujeito e à sua própria saúde. A visão fragmentada do campo dos determinantes sociais da saúde é o que colocamos em análise e produzimos questionamentos como forma de suscitar futuros debates sobre o tema em questão.

Palavras-chave: Iniquidade Social; Desigualdades em Saúde; Ciências Sociais; Saúde Coletiva.

Introduction

The most recent transformations stemming from the current phase of capitalist expansion, characterized by the globalization of the economy, by technological advances and its most visible consequences, such as increased inequality and social injustice, has rekindled the debate on the “social issue” in various sectors of society. In the area of health, in particular, this debate has been growing and has formed a field of academic-political discussion, now known as “social determinants of health”.

Thus, various authors have brought reflections to the debate concerning the new global political context in which this topic reappears. Villar (2007) contextualizes this reappearance in the face of a global situation characterized by the exhaustion of the neoliberal model, as a result of prioritizing economic growth to the detriment of social development. For the author, this has increased the tensions produced by health inequalities, leading to the reappearance of concern for social justice.

Nogueira (2009) gives us a broader view of this new international political-economic context, which he considers a post-neoliberal trend, very different from that experienced in the 80s and 90s, in which restraining costs forced the creation of minimal social packages, proposed by international agencies. According to this author, this new situation, characterized by overcoming tax hikes, made such agencies recognize and value a broader meaning of social protection to be adopted in countries, seeking not only to combat absolute poverty but also social inequality (albeit in a fairly narrow concept of social inequality).

This post-neoliberal context of policies appeared in association with a global tendency of forming blocks of countries with integrated markets, repudiating extreme inequality, not only for its ethical dimension - social justice -, but also for market interests, as such inequality makes it impossible for certain social groups to participate in the new integrated market that begins to emerge (Nogueira, 2009).

It is in this heterogeneous, uncertain and multifaceted context that this article discusses the recent debate coming from the field of social determinants

of health, especially in relation to the predominant view of “social”. In order to do this, an exploratory study was conducted, using bibliographical research of the output of two specific authors: Latour (2012) and Santos (1988). These different theoretical views make it possible to appropriate elements of analysis, categories and useful concepts for establishing the critique we propose.

Initially, we characterized the field of social determinants of health, along general lines, especially from a political-scientific point of view. Next, we outlined the critique of this field, characterizing two approaches of thought, based on the above mentioned authors. Two categories of analysis were essential in establishing this critique: Latour’s (2012) idea of the social that needs to be “re-aggregated” and the passage from a science of control to a science of understanding, as argued by Santos (1988).

It is worth noting that we have taken the concept of “field” according to the reference produced by Bourdieu (2004). For this author, the concept of field is understood as a particular and heterogeneous space, in which relationships of power manifest themselves through an indefinable correlation of forces between agents searching to preserve or transform them, in other words, it is “[...] social world, like others, but obeying more or less specific social laws” (Bourdieu, 2004, p. 20).

The field of social determinants of health

The discussion of the “social” once again took a prominent place on the health sector’s political agenda in 2005, when the World Health Organization (WHO) created the Commission on Social Determinants of Health (CSDH), aiming to promote, on an international level, recognition of the importance of social determinants in the health situation of individuals and populations and on the need to combat health inequalities produced thereby (Buss and Pellegrini-Filho, 2007).

This commission was charged with collecting, systemizing and synthesizing evidence on social determinants of health and its impact on health inequalities, as well as producing recommendations for action. For the commission, “social determinants

of health are constituted by structural determinants and day-to-day living conditions and are responsible for the majority of health inequalities between and within countries” (Portugal, 2010, p. 1).

Thus, in response to the global movement concerning social determinants of health triggered by the WHO, the Brazilian National Commission on Social Determinants of Health (NCS DH) was created in March 2006. Established through Presidential Decree, with a two year mandate, the NCS DH brought the discussion on the need to intervene in social determinants in search of health equality to the Brazilian political agenda (Brasil, 2006).

The NCS DH worked using the concept of health as defined by the WHO and adopted Dahlgren and Whitehead’s conceptual model of social determinants of health (Brasil, 2008). In this conceptual model, the social determinants of health are approached in different layers, from those that express individual characteristics of individuals, passing through those that represent individual behavior and lifestyle, to more intermediary layers, represented by community and support networks. Next are factors related to the individual’s living and working conditions, finalized by the layer expressing macro-determinants related to economic, social and environmental conditions (Buss and Pellegrini-Filho, 2007).

As we will see, the Brazilian political option of “importing” this conceptual model has direct and intense implications on the way scientific knowledge will be produced in this field. That is, Brazilian studies on social determinants would mostly opt to socially fragment the layers, situations and/or particular conditions. Thus, the “social” would be understood as something static, a “snapshot”, to which it would be possible to return in order to explain the health status of individuals.

In April 2008, with the publishing of their final report entitled “The Social Causes of Health Inequalities in Brazil”, the NCS DH recommended that action on social determinants should be based on three key pillars: intersectorial actions aiming to improve quality of life and health; social participation and promoting autonomy of the most vulnerable population groups; and the scientific evidence, incorporating systematic production of information and knowledge of the relationships between social

determinants and health, as well as evaluating the interventions produced (Brasil, 2008). As Brazil was a pioneer in introducing this topic into their policy, in October 2011 it played host to the 1st Global Conference on Social Determinants of Health. The “Rio Declaration”, the final document of this conference, highlights five strategic areas for achieving health equality: improving governance in the field of health and development; encouraging social participation in formulating and implementing public policy; promoting the construction of health care systems aimed at reducing health inequality; strengthening governance and global collaboration in health; and monitoring advances (WHO, 2011).

Some criticisms were levelled at the World Health Organization (WHO)’s approach concerning the form in which the topic of health determinants reappeared in the discourse. For Nogueira (2009), the international political-economic context in which the topic was once again taken up means that, in the WHO report itself, the social determinants of health are analyzed in a reductionist and fragmentary way. This debate was presented and discussed in the positioning of the Latin American Association of Social Medicine and published by the Brazilian Center for Health Studies in 2011 (Cebes, 2011), requesting that the concept of social determinants not be reduced or trivialized, but rather to bear in mind that, behind all reductionism of the concept was a clear idea of the commodification and trivialization of life.

Arellano et al. (2008) discuss the inadequacy of WHO recommendations in improving understanding of the origin of problems concerning health inequalities. Among the various limitations pointed out by these authors, we highlight:

- Reducing the problem of social inequalities to a problem with distribution, limited to the plan of “improving living conditions” and “allocating resources”;
- The fragmentation of social reality in analyzing the health situation according to social factors, losing the dimension of socio-historical processes; and
- The lack of reflection and critical analysis of the devaluation of the population’s life and health, imposed by capitalism’s current stage of develop-

ment, as well as silence surrounding problems such as war and genocide, causing deaths and massive suffering to populations (Arellano et al., 2008).

Revisiting the current political scene in which social determinants of health are inserted, it is worth asking in what form the field of academic-scientific output configures itself. In Brazil, this output of scientific knowledge comes to stand out in the field of Collective or Public Health, a field in which there is currently a growing number of studies involving the relationship between social determinants and social inequalities. In general, these studies have been characterized by the importance of the use of scientific evidence in approaching the topic.

Pellegrini Filho (2011) emphasizes this tool, reinforcing its capacity to assist in defining intersectorial public policies, emphasizing the difficulties in producing and using the scientific evidence on which action on social determinants are based, such as those from using randomized clinical studies (which the author considers to be more reliable sources of scientific evidence) to evaluate interventions in communities, this author states that it is a new movement combining new tools, methodologies and approaches capable of imprinting a new characteristic on Public Health.

With such emphasis placed on scientific evidence, the predominance of epidemiological approaches in the output of knowledge in this field is notable. From this perspective, social determinants are approached in isolation, according to the objective of each study, according to layers/strata (demographic characteristics, socio-economic, cultural and environmental conditions, social support networks, living and working conditions and lifestyle) and correlated with morbi-mortality between different social groups.

Faced with this statement, Nogueira (2010) affirms that the seemingly new field of studies on social determinants of health ends up reproducing the positivist perspective that guided traditional epidemiology. For Tambellini and Schütz (2009), such a perspective should be understood by the paths constructed within the established limits by the hegemonic power in Western societies, making “social determinants of health” equivalent to the

process of “social determination of health”, when the vast majority of studies are justified by the importance of supporting public policies through evaluating social conditions that determine health in certain population groups.

However, Fleury-Teixeira and Bronzo (2010) show the deficiencies in these studies in supporting policies, stating that “the impression given is that the pile of research linking health conditions in population groups to diverse social determinants does not achieve a more active meaning in the spaces in which deliberation and public decision making take place” (p. 41). Thus, understanding “social determination of health” proceeds in the direction of technical and scientific production of political projects that are contra-hegemonic in the Latin American situation, and is marked by the emergence of Public Health. This latter perspective develops an analysis of “social determination of health” in light of references to Marxist theory.

Based on the above mentioned authors, a contra-hegemonic current can be noted, supporting critique of the excessively casuistic approach that marks this field, principally in stating the need to promote the production of knowledge on the topic through other processes of analysis, based on the contribution of references coming from social and human sciences based on social health theory (Nogueira, 2010).

Thus, we survey elements we consider to be essential for a more in-depth discussion of social determinants of health, aiming to assist thinking beyond the reductionism that often marks this field. Our aim is to present a line of argument that collaborates with studies on the field of social determinants of health.

Elements for the debate on social determinants of health

In the scientific field, the model of rationality - hegemonic in modern science - has been questioned and criticized by many authors. The principal characteristic of this model, initially developed in the area of natural sciences (based on the scientific revolution of the 16th century), was formulating universal laws and establishing a theoretical assumption, based on the idea of order and stability in the world. Later,

(from the 19th century onwards), this was extended to the social science domain, as a model equally possible for discovering the laws of society. The principal paradigms were: the total separation of nature and the human being and the centrality of mathematics in characterizing scientific investigation, resulting in priority being given to quantifying, as well as to dividing and classifying elements (Santos, 1988).

Especially in relation to the social science domain, authors such as Santos (1988) and Latour (2012) established sustained critiques demonstrating the way in which this rational model, originating in the field of natural sciences, has also been hegemonic in guiding studies of the social, as well as the consequences of this approach.

According to Santos (1988), this model was introduced into the field of social sciences based on the assumption that social phenomena should be studied in the same way as natural phenomena, meaning they were conceived as “things”. To do this, the need to be reduced to their most external dimensions, capable of being measured. Latour (2012) states that this conception leads to a rain of fragments, altering modes of existence through the great proliferation of objects “of risk” that show that social ties also become fragments in the hands of technical organizations.

Current epidemiological studies in the field of social determinants of health are a possible example of the force of this assumption, as they are based on outlines of social phenomena judged able to be delineated, isolated and quantified, such as, for example, choosing variables such as levels of income or schooling to characterize the phenomenon of social inequality.

Latour (2012), therefore, states that “it does not matter how difficult it is to conduct such studies, they manage to imitate the success of natural sciences up to a point, when they show themselves to be as objective as other disciplines, thanks to the use of quantitative tools” (p. 21). According to Santos (1988), the limits of this type of knowledge can be found exactly in their quantitative nature in which ever more precise data is sought, showing themselves to be limited for their extreme and progressive “parcelization of the object” distorting knowledge of the whole into as many fragments as possible.

The words “social” and “nature” often conceal two entirely distinct projects [...]: finding connections between unlikely entities and making them lasting as a whole up to a certain consistent point. The mistake is not in attempting two things at the same time - all science is also a political project -, but rather in halting the former because of the urgency of the latter (Latour, 2012, p. 368).

Latour (2012), developing a critique of modern studies of the “social”, states that the scientific rationality of modernity judges it necessary to distinguish and separate the sociological domain from others, such as the economy, law, psychology, biology and geography among others. In this way, sociology defines a specific social domain of reality as something particular and different to others. From this rational perspective, it falls to sociology to study the “social” as a specific “object”, differentiated from other type of knowledge, so as to provide a certain type of explanation for other disciplines of that which they judge not to be in their jurisdiction.

Thus, the “context” of the social as a “specific” dimension of reality can be used as a type of causality in order to explain “residual” aspects for which other disciplines cannot account: “the social clarifying the social” (Latour, 2012, p. 20). For example, law, although with its own capacity, would be more comprehensible if a social domain was added to it, as would psychology, which relies on certain aspects of social influence to explain an individual’s internal motives (Latour, 2012).

This restricted view of the social is common sense, not only for “laymen” in the subject, but also within the environment of social sciences (Latour, 2012). And even within this common sense, this “specific phenomenon” has various other labels - “society”, “social practice”, “social structure” or “social order” (Latour, 2012, p. 19) - chosen according to the specific objective of the aim of the analysis, even showing a clear etymological trend in the term “social” which, as the author clearly points out, acquires a meaning that is not only increasingly varied and segmented, but also more limited:

The root is *seq-*, *sequi*, and the first meaning is “follow”. The Latin *socius* denotes a companion, an associate. In different languages, the historical genealogy of the word “social” designates first “to

follow someone”, next to “enlist” and “ally oneself with”, finally expressing “something in common”. Another meaning is “to be part of a commercial enterprise”. “Social” as in “social contract” is an invention of Rousseau. “Social” as in “social problems” or “social issues” is a 19th century innovation 19 (Latour, 2012, p. 24).

The field of health is a paradigmatic example of this situation, beginning with the division of disciplines in the academic area, in which sociology is given in a parallel way, unrelated to other disciplines, placing the social as an “external dimension” to the health-disease process. The term “social determinants of health” clearly explains the polarity established between the “social” and “health” when seeking a specific “social explanation” for a phenomenon (health), a dimension that is inseparable from the social totality.

Another evident example is that of so-called “external causes” (name used in the area of health to denominate accidents and the most varied forms of violence), a term that, in itself, reveals how these complex social phenomena are reduced and grouped together in a mere external category decontextualized from the health care sector, so they are not discussed as phenomena intrinsic to the dynamic of collective life, an expression of the way society is organized (of which health is a constitutive part), but reduced simply to “social factors” capable of explaining the increasing numbers of deaths, injuries and incapacities resulting from them. Thus, the health sector marginalizes their responsibility in the search for these “causes”, as they are on an “external” plane out of their reach. Moreover, these two examples, common to the day-to-day experience of those who work in the “health sector”, demonstrate the conflict, the polarity, established between the “biological being” and the “social being”, as if they were two distinct beings. It is in this logic that individual with specific diseases, as well as being “dissected” by diverse medical specialties, is not considered as the same individual who suffers from domestic violence, who has precarious living and working conditions, who depends on welfare policies to survive. Thus, the being, in all its complexities of existence, is “layered” in distinct dimensions; biological being - “investigated by doctors, nurses,

physiotherapists and dentists, among other health care professionals; the social being for social workers; the psychological being for psychologists.

The growing inclusion of social care into health care services reveals the deficiencies of both sectors, and especially those of health care teams in dealing with the “social”, as this is something that is referred to another institution as soon as it is diagnosed, as it is beyond the scope of health care teams. And, as the health care sector cannot “take account of the social”, it therefore turns to other sectors. In other words, it is about uniting what was dispersed, regrouping what was divided, socialize what had been individualized: the much acclaimed intersectoriality, recommended in the vast majority of technical and policy documents in the field of Social Determinants of Health.

However, this model of rationality - currently called into question - has not only fragmented and externalized the social, but also, above all, has emphasized the idea that the social determines the individuals, so in order to understand each individual it becomes necessary - a *sine qua non* condition - to understand the social logic around him, always deemed more “powerful” or greater than individual will, in other words, bringing the individual to be a mere reproduction of the collective structures determining him.

Faced with the crisis of the modern paradigm of scientific rationality, which fragments and disperses the social, Latour (2012) and Santos (1988) place their faith in the growth of a new paradigm. This emerging paradigm is supported by science that goes beyond the idea of a controlled and manipulated world to one which is comprehensible. A paradigm that states the need for metaphysical and cultural assumptions, and systems of belief to be integrated in scientific explanations of nature and of society, overcoming the subject-object, observer-observed, natural-social, mind-matter, collective-individuals dichotomy (Santos, 1988).

Latour (2012) argues for a new approach to the social that includes convergence as an arrival point, not as a starting point. An approach that is, above all, capable of overcoming the basic assumption of that dominant approach, stating that there is nothing specific in the social order, that the social should

not be viewed as a particular thing or a specific reality. This approach is about regrouping, redefining and re-establishing connections and associations provided by specific and heterogeneous domains of the social reality so as to understand the phenomena based on established social relationships. This means, in addition to methods capable of quantifying reality, also incorporating methods that rely on understanding the subjective reality of the “other” in collective life. It assumes, therefore, based on in-depth common sense understanding - what modern science has repudiated - as it “reproduces itself bonded to the trajectories and experiences of life of a given social group and is reliable and reassuring in this correspondence” (Santos, 1988, p. 70).

In this approach, the social should be used as a specific object, external to the field of health, so that the term “social determinants of health” becomes redundant, signifying a rethink of knowledge and practice beyond the biomedical, sectorial and specialized sector. To reach a better understanding of what the social is, the following is advisable: abandon the notion of health as a “given”; deconstruct, then reconstruct, knowledge, values and practice; definitively incorporate knowledge from the human and social sciences, from anthropology and history, among others. It is a better, but never exact, understanding, as the social is not a given, it is lived, it is dynamic, it is constructed and transformed for each one and for everyone at the same time.

Final considerations

The WHO’s entrance into the arena of discussing and encouraging policies to combat social inequalities occurred together with specific post neo-liberal political-economic conditions and the progressive formation of integrated markets, in which the interests of capital expansion could be found between the lines of objectives promoting social justice. It is in this political-economic situation that the Commission on Social Determinants of Health was created by the WHO in 2005, so as to revive the discussion of the “social” in analyzing and understanding the health-disease process, as well as making official, within global political discourse, the alert for our need to intervene in order to overcome the signifi-

cant health inequalities they produce. This revival cause intense agitation within the area producing scientific knowledge on social determinants of health, with the growing prioritization and emphasis on producing studies, in different approaches, aiming to understand and/or explain the relationships established between the “social” and “health”.

It is in this sense that we understand how the field of social determinants of health configures itself, as it is far from homogenous, to the extent to which conflicts of interest between its agents are revealed, in a constant correlation of forces, seeking legitimacy. According to Bourdieu (2004, p. 22), “[...] the heteronomy of a field essentially manifests itself, due to the fact that exterior problems, especially political problems, are directly expressed there”. In this field, the predominant focus in the approach is social determination of health, reducing and fragmenting the dynamic and complex social phenomenon to “social factors”, ends up in reproducing the notion of health as an object external to the subject and further dichotomizing the individual and the social.

We believe that the permanence of this fragmented approach to the social, far from demonstrating advances from an academic and political point of view, merely maintains and reproduces the rationalist logic, so dear to the dominant economic groups, to global interests and to maintaining the *status quo*.

We were able to reflect on the field of knowledge production and health practices in order to discuss the debate on the social, as well as indicators, factors and causalities. Thus, we seek to demonstrate some of the reductionisms that are increasingly present in approaching the social. Reductionisms that end up limiting the complexity of life in society with the normalizing and medicalizing power of the biomedical model, locating not only the origin but also the solution to “health problems” in the biological, cellular, individual body and reinforcing the commercialization of life.

Of the paths indicated by Santos (1988), we chose that which alerts us to the modernization of science, a supposed scientific revolution occurring in our times. Santos (1988) observes that current science

cannot be limited to simply producing a scientific paradigm - the paradigm of prudent knowledge -, it also has to be a social paradigm - a paradigm of decent life.

On the other hand, the thinking of Latour (2012) posed arguments to rethink what we currently understand “social” to be. Beyond a specific domain, and limited to the reality, as something always external to the subject and to their own health, the author convokes us all, specialists in different disciplines, to re-discuss it as a complex reality, inherent to all these domains and thus in need of the contribution of each in order to be understood as a convergent movement, of arrival and not of “starting point” (this term here is understood with the double meaning: both of the place something starts, as well as meaning “fractioning”, “division”) - what the author calls an attempt to “regroup the social”.

For our part, we insist that the “social” is not something external to the subject, to their health and much less to Public Health, but rather something that should recover the social base sustaining it as a historically, collectively constructed field of knowledge, practices and values, transformed and committed to a fairer, less unequal and, therefore, happier world.

Authors’ contribution

The authors worked together at all stages of producing the manuscript.

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Received: 20/05/2013
Resubmitted: 16/01/2014
Approved: 05/05/2014