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Concepts, disciplines and politics: On 'structural violence' and the 'social determinants of health'

Clare Herrick[1] & Kirsten Bell[2]

[1] Department of Geography, Kings College London

[2] Centre for Research in Evolutionary, Social and Inter-Disciplinary Anthropology, University of Roehampton

Abstract

It has long been recognised that human health is indelibly shaped by a variety of factors. These include pathogens such as bacteria and viruses, but also broad-ranging social, economic and political forces operating at different spatial scales. In seeking to understand the nature and effects of these forces, two concepts have become particularly influential: the 'social determinants of health' and 'structural violence'. In this paper, we critically examine their origins, tracing their 'prehistory' and little-recognised intersections, based on searches of both concepts in PubMed and Google Scholar, and a critical reading of the range of texts our searches produced. This forms the groundwork from which we examine their similarities and differences, and their potentialities and limitations. We demonstrate that both concepts operate largely as black boxes. Their usage has thus become tied to disciplinary and methodological projects, with attendant implications for their wider usage – especially given the respective statuses of the fields of medical anthropology and social epidemiology in public health. We conclude that structural violence and the social determinants of health have both been influential in research and policy, but have struggled to effect the kinds of political change that their moral commitment to social justice promises and that further dialogue between them is required.

Keywords: social determinants of health, structural violence, health inequalities, disciplinarity, terminology, global health

Introduction

For well over a century, a variety of scholars – from Rudolf Virchow and Fredrich Engels to Emile Durkheim – have been concerned with social influences on health. The sanitary reform efforts of the nineteenth and early twentieth century, for example, were acutely focused on the social and environmental drivers of health; these were also affirmed in the World Health Organization's constitution and the Alma-Ata Declaration in 1978. Likewise, other reports of the period, including Canada's *Lalonde Report*, placed a similar emphasis on the 'health field', or the broader social, economic and environmental drivers of health and health inequalities. Indeed, interest in these areas has markedly intensified over the past three decades in the fields of epidemiology and public health (Bouchard *et al.*, 2015). However, while concerns with the effects of 'the social' on health are longstanding, they have been conceptualised in a variety of ways and, as this paper will explore, had a marked influence on disciplinary approaches to health and wellbeing.

In what follows, we are interested in two concepts that have become widely used in the twenty-first century to describe the influence of social, economic and political forces on health: the *social determinants of health* and *structural violence*. Both concepts posit that deaths are not inevitable, natural or equitable but instead are biological reflections of social inequality. In many respects, the work these two concepts are intended to do is therefore similar. Despite this, and as we will explore, they have evolved along largely parallel disciplinary tracks. According to Fu *et al.*,

> The language of 'social determinants' of health is commonly used in social epidemiology and medical sociology, which conceives a causal relationship between inequality/deprivation and health.... The notion of 'structural violence' is used widely in anthropological analyses of health inequality. This concept highlights violence of hierarchical power structures in the creation and reproduction of inequality and seeks to identify the structures more directly (2015, p. 227).

In shedding light on how and why the social determinants of health have emerged as a dominant explanatory paradigm in public health and epidemiology, while structural violence has arisen as a hallmark of medical anthropology, this paper examines how concepts function within the disciplinary paradigms that characterise the study of health. Interrogating the pathways and influence of these ideas thus illuminates how and why concepts get taken up, how they mark disciplinary boundaries, their capacity to cross them, the work they are intended to do, and the reality of their capacity to effect change. In so doing, we do not intend to advocate for (or against) one or the other concept. Instead, our aim is to de-naturalise them – to examine their origins, question their application, explore their points of synergy and difference, and shed light on what they have come to signify within particular disciplinary traditions.

To aid our analysis, we conducted searches in September 2019 of the 'social determinants of health' and 'structural violence' in PubMed to explore how and where they have been cited. We also conducted Google Scholar searches between September-December 2019 – we chose this database rather than Web of Science because the latter is far more limited in its coverage (Kulkarni *et al.*, 2009). Keyword searches of both terms were followed by separate searches of the primary identified publications (e.g., Galtung 1969; Farmer, 1996; Farmer 1999; Farmer 2004; Wilkinson, 1996; Marmot & Wilkinson, 1999) to explore how, where and in what contexts they have been cited. We engaged in a critical reading of the many hundreds of texts our searches produced, including scholarly literature and policy documents. In numerous instances, we focused on the title, abstract, keywords, year of publication and publisher; in others, we read documents in their entirety, downloading them as PDFs and doing keyword searches to see how the terms were being used.

Our hope is that this analysis will ignite much-needed reflection on the utility and significance of both concepts and the disciplinary (re)production of conceptual traditions. In keeping with this goal, we first outline the origins or 'pre-history' of structural violence and the social determinants of health, before turning to their points of synergy and difference, as well as the criticisms levelled at them. In doing so, we draw out their potentiality, promise and the reality of their capacity to effect the real change needed to improve human health outcomes.

Structural violence: its 'prehistory' and Farmer's popularisation

The formal roots of the concept of structural violence date back to 1969 and Johan Galtung's article 'Violence, peace, and peace research', which was published in Galtung's *Journal of Peace Research* – the first specialist publication in the burgeoning interdisciplinary field of peace studies. In the article, Galtung uses the term 'structural violence' as one dimension of his six-fold typology of violence. In his words,

> We shall refer to the type of violence where there is an actor that commits the violence as personal or direct, and to violence where there is no such actor as structural or indirect... There may not be any person who directly harms another person in the structure. The violence is built into the structure and shows up as unequal power and consequently as unequal life chances (1969, p. 170).

Over the next decade, the concept was widely discussed (and critiqued) in the pages of the journal, with numerous scholars, including Galtung himself, concerned with how to operationalise it in understanding patterns of mortality. As these publications make clear, the

goal of scholars working in this area was to 'formulate a comprehensive, empirically validated theory of structural violence which would explain variations and changes in the magnitudes of structural violence', although they acknowledged that 'such theory is a long way off' (Alcock & Köhler, 1979, p. 256).

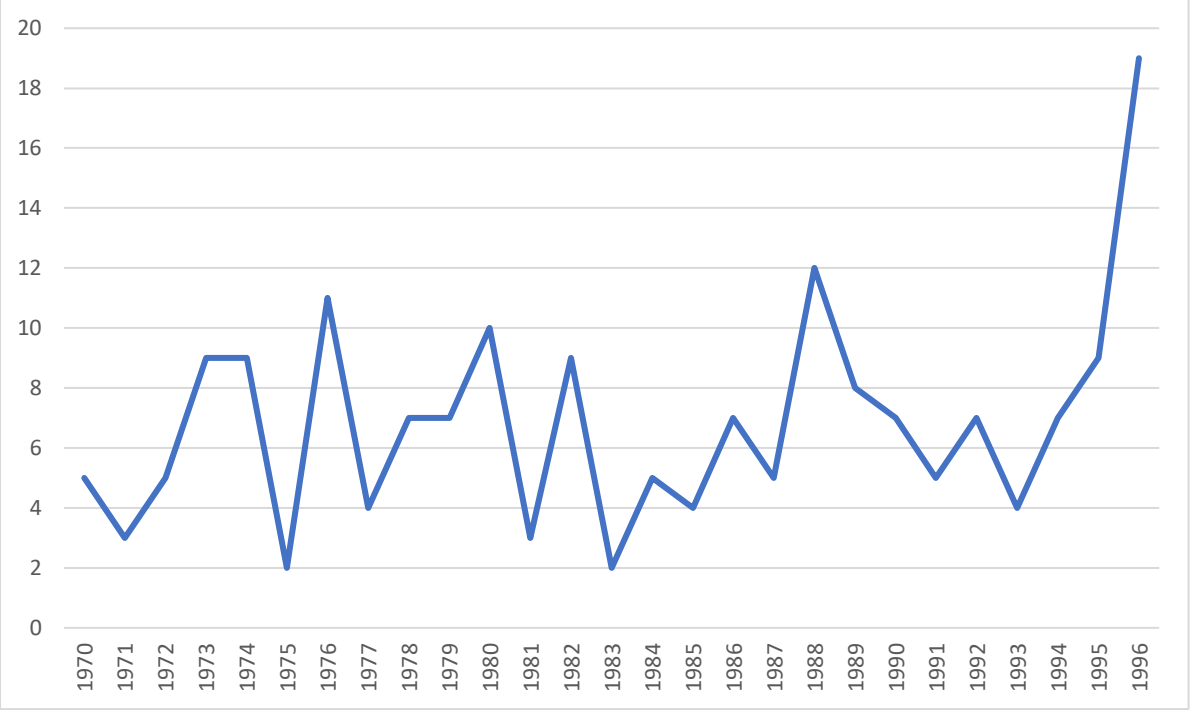

Figure 1. Citations in Google Scholar for Galtung's 1969 paper during its 'prehistory' (1970-1996)

While the concept of structural violence was cited intensively in Galtung's journal, there is clear evidence of wider dissemination beyond its pages in the period before it was popularised by other scholars. According to Google Scholar, between 1969 and 1996 there were 168 citations for Galtung's paper (see figure 1), of which only 33 were from articles published in the *Journal of Peace Research*. The breadth of its diffusion is illustrated in a 1986 article published in an applied philosophy journal, where the author characterises structural violence as a currently 'fashionable definition' (Coady, 1986, p. 3), and raises a variety of concerns about the overextension of the term 'violence' to cover a range of social injustices and inequalities. Despite these internal and external critiques, in the mid-to-late 1990s the concept had independently caught the imaginations of scholars working in various disciplines, including the political scientist Peter Uvin (1998) and Paul Farmer, a physician and medical anthropologist.

Farmer first used the concept of structural violence in a 1996 paper titled 'On suffering and structural violence: A view from below' published in *Daedalus* – the flagship journal of the

American Academy of Arts and Sciences. Via a series of fine-grained ethnographic case studies, Farmer highlights the social, economic and political forces shaping the HIV epidemic in Haiti, namely: 'racism, sexism, political violence and grinding poverty' (1996, p. 13). In the paper, structural violence is secondary to Farmer's concern with suffering. Indeed, while tantalisingly in the paper's title, structural violence is used largely as a synonym for 'social forces' – the term he favours throughout his earliest book *AIDS and Accusation* (1992), which was drawn from his PhD research in Haiti. To quote from the first time the term is used in the paper: 'they were both, from the outset, victims of structural violence' (1996, p. 19). It is used in much the same way in Farmer's subsequent publications (Farmer *et al.*, 1996; Farmer, 1997, 2001) – namely, as a self-evident 'thing' or abstract set of uncontrollable forces and causal influences, rather than a concept or theory *per se*.

Although these early publications were primarily targeting an interdisciplinary readership, Farmer's development and deployment of structural violence cannot be dissociated from his disenchantment with medical anthropology's tendency to focus on cultural relativism at the expense of political economy (Haricharan, 2008). In the context of HIV/AIDS research in the 1980s and 1990s, he drew attention to the discipline's 'conflation of structural violence and cultural difference' (1997, p. 355) and the 'blindness to inequality' (2001, p. 6) it had produced. Structural violence was thus a way of highlighting 'a political economy of brutality' (1996, p. 274) that was otherwise hidden in anthropological studies – especially accounts of HIV. For Farmer, writing at a time of the World Bank-influenced turn to 'cost-effectiveness' and 'selective primary healthcare' (Cueto, 2004) in global health, the prevailing culturalist approach justified vastly different standards in care between global north and south – a further source of gross social injustice that has consistently angered Farmer. Thus, in this early work, structural violence arguably emerged more as a disciplinary *corrective* than as a *concept* in its own right. For him, it was an antidote to medical anthropology's insularity and a frustration at the field's unwillingness 'to learn the basics of infectious disease or epidemiology even when they are related to our chosen arenas of intervention' (Farmer, 1997, p. 355).

A shift in Farmer's use of the term begins in his 2004 paper, 'An anthropology of structural violence' and his book *Pathologies of Power*, which he likewise frames as a 'contribution to a critical anthropology of structural violence' (2005, p. 28). For the first time, Farmer presents structural violence as a concept rather than a self-evident fact, although he continues to use the term primarily as a heuristic device. Galtung is now cited in terms of acknowledging the roots of

the *term* 'structural violence', which Farmer implicitly differentiates from his own development of the *concept*. In Farmer's words:

> Just as everyone seems to have his or her own definitions of 'structure' and 'violence,' so too does the term 'structural violence' cause epistemological jitters in our ranks. It dates back at least to 1969, to Johan Galtung, as well as the Latin American liberation theologians. The latter used the term broadly to describe 'sinful' social structures characterized by poverty and steep grades of social inequality, including racism and gender inequality (2004, p. 307; see also 2005, p. 8).

This tendency to downplay Galtung's influence has been rectified in Farmer's more recent publications (e.g., Farmer *et al.*, 2006; Rylko-Bauer & Farmer, 2016). However, a lack of familiarity with the concept's 'prehistory' means that, among anthropologists at least, Farmer – rather than Galtung – is often credited with theorising its core attributes. Nevertheless, Farmer has played a key role in disseminating the concept of structural violence within the field of global health, especially in the area of HIV/AIDS. For example, its influence is evident in UNAIDS' growing emphasis on 'structural vulnerability' and poverty reduction in its approach to HIV (UNAIDS, 2001), despite the criticism it drew from various epidemiologists regarding what they saw as the lack of scientific support for such approaches (e.g., Chin, 2007; Epstein, 2008). Evidence, as we will discuss in further detail below, has always presented an issue for the concept of structural violence. In this respect, its history is rather different from that of the social determinants of health.

The social determinants of health: Conceptualising evidence of inequality

In stark contrast to the Haitian origins and global health application of Paul Farmer's work, the 'social determinants of health' framework emerged from the work of two British academics – Richard Wilkinson and Michael Marmot – documenting consistent social gradients in morbidity and mortality in the UK (Boseley, 2008). Noting that social class differences in mortality rates had widened considerably from the 1930s to the 1970s, despite the establishment of the National Health Service, Wilkinson's master's thesis explored the role of different social and economic indicators in explaining this gap (Berridge, 2002).. The dissertation's findings were picked up by the press and, emboldened, Wilkinson penned an open letter to the then-Secretary of State for Health Services issuing a demand to set up an 'urgent inquiry' to look into the issue of class differences in mortality and to recommend concrete action (Wilkinson, 1976). The resultant political pressure culminated in the controversial (and covered-up) *Black Report* (1980), and the UK's commitment to reduce health inequalities by 2000 (World Health Organization, 1985), along with further reports that continued to highlight widening health inequalities, such as *The Health Divide* (Whitehead, 1987).

In 1996, Wilkinson published *Unhealthy Societies: The Afflictions of Inequality*, in which he uses the term 'social determinants' on three occasions. In the book he argues that 'the analysis of the socioeconomic determinants of death rates is a particularly important guide to understanding social welfare... It is also important because the social determinants of health provide essential insights into the way social structures impose psychic damage and human costs' (1996, p. 23). Wilkinson further asserts that 'public understanding of the social determinants of health has grown rapidly over the last two decades. Everyone now knows that the poor have worse health and a shorter life expectancy than the rich' (1996, p. 24). He also draws attention to the ways in which 'recognition of the social determinants of health will improve the quality of life as well as health' (1996, p. 25) by providing the basis for 'a reform of the *social environment* equivalent to the reforms of the physical environment brought about by the public health movement initiated in the Victorian era' (*ibid,* emphasis added).

Marmot's work on the Whitehall Studies are some of the best known on the social gradient in health (Boseley, 2008) and their influence extended far beyond the UK setting. He has long argued that class differences in health outcomes – of the type made so clear in the Whitehall Studies' exposition of the near-universal pattern of better health outcomes amongst those more senior in the civil service hierarchy – are both unfair and a clear barometer of how well society is functioning, or, in his language, 'flourishing'. In 1999, Marmot and Wilkinson published their edited book, *Social Determinants of Health.* They were both also contributors to a WHO Regional Office for Europe publication entitled *The Social Determinants of Health: The Solid Facts* published in the same year.

The book traces its roots to a number of research traditions: the health gradient, the 'causes of the causes' or the 'pathways by which social circumstances affect health' (Marmot & Wilkinson, 1998, p. 3), and an appreciation of the material, economic, behavioural and psychosocial pathways affecting health. As they argue, this has 'led in particular to a growing understanding of the remarkable sensitivity of health to the social environment and to what have become known as the social determinants of health' (Wilkinson & Marmot, 2003, p. 7). Their aim is to 'give definition to the social determinants of health – to unpick the social environment – in order to be more precise about policy making' (1998, p. 4). While they acknowledge that there is great scope to improve the evidence base around this, they stress that 'we need more social action on the basis of the knowledge that we have' (1998, p. 5). It is notable that Marmot would become

the Chair of the Scientific Reference Group on Health Inequalities under Tony Blair's New Labour government.

Shifting from the national scale of the UK to the global, these publications were instrumental in the development of the *WHO Commission on the Social Determinants of Health* (CSDH), which was launched in 2005 by the then-Director General, Lee Jong-Wook, who took office on a platform emphasising a commitment to health equity and social justice (Solar & Irwin, 2010). Importantly, the CSDH would be oriented towards practical action and providing guidance to other WHO programmes. The establishment of the CSDH came at an opportune moment in which the evidence base to support work on the social determinants of health was growing rapidly, largely thanks to the expansion of the Global Burden of Disease Survey. Moreover, the survey allowed the social determinants of health concept to emerge from an argument about inequalities *within* countries, to an ever-more sophisticated concern with inequalities *between* people *and* countries as the remit of the approach expanded from the UK's domestic context to the arena of global health.

Two years after being convened, the Commission released its interim report and, a year later in 2008, *Closing the Gap in a Generation* was published. The opening pages of the report set the moral tone for what follows:

> The poor health of the poor, the social gradient in health within countries, and the marked health inequities between countries are caused by the *unequal distribution* of power, income, goods, and services, globally and nationally, the consequent *unfairness* in the immediate, visible circumstances of people's lives... and their chances of leading a *flourishing* life. This unequal distribution of health-damaging experiences is not in any sense a 'natural' phenomenon but is the result of a *toxic* combination of poor social policies and programmes, *unfair* economic arrangements, and *bad politics*. Together, the structural determinants and conditions of daily life constitute the social determinants of health and are responsible for a major part of health inequities between and within countries (World Health Organization, 2008, p. 1, emphasis added).

The report argues that action and policy should aim to improve population health – for health acts as a barometer of societal flourishing – and consequently strengthen health equity. It further recommends action to address the 'proximate' circumstances of daily life and 'distal' structural drivers, including social stratification, societal biases, norms and values, global and national economic and social policies and governance processes. For the CSDH, the clear focus is therefore not merely to uplift the health and address the suffering of the *very poorest* (as argued in Farmer's structural violence), but rather to tackle the ubiquitous *social gradient in health* as a means of realising the goal of health equity. This ambition is evident in the concluding remarks

of the report, which emphasise: 'a vision to create a better and fairer world where people's life chances and their health will no longer be blighted by the accident of where they happen to be born, the colour of their skin, or the lack of opportunities afforded to their parents' (Marmot *et al.*, 2008, p. 1668).

Parallels, intersections and disjunctures

As these historical overviews suggest, both frameworks emerged during a similar timeframe – tracing their roots to the 1970s, gaining ideological steam at the height of the neoliberal project (and its attendant effects on inequality) in the late 1990s, and with evidence of policy uptake in the twenty-first century. The concepts also similarly draw attention to the unequal distribution of power, social injustice and suffering, and their effects on people's capacity to live healthy lives. In doing so, they challenge the epidemiological tendency to focus on the individual and their risk factors and thus call into question individual agency. However, they are equally characterised by a degree of definitional vagueness. Structural violence, in Farmer's usage, was never more than a broad heuristic device – in contrast with Galtung's earlier attempts to operationalise 'notions of agency and causation with respect to violent effects' (Nixon, 2011, p. 11). Likewise, despite the technical precision of research on the social determinants of health, material and structural factors are often studied as 'proxies for social structure and each variable is not understood in terms of its relation to other elements in the system, nor in terms of how it is manifested in and reinforced by social practices' (Frohlich *et al.*, 2001, p. 781). Indeed, at a policy level the social determinants of health tend to operate as a conceptual black box for 'nonmedical' influences on health, with definitions including everything from concrete indicators such as income and education levels, to more abstract philosophical concepts such as 'freedom' itself (see Bell, 2017).

Yet, despite their many parallels – including the debt both owe to the work and influence of Amartya Sen's work on capabilities (cf. Marmot, 2005; Farmer, 2005) and their concern with social injustice – they have only sporadically crossed paths within or between disciplines. There are, however, some indications that their primary authors and elaborators were aware of the synergies between the concepts. For example, Marmot (2005, p. 1102) cites Farmer in passing in the context of statements such as, 'A focus on material conditions and control of infectious diseases must not be to the exclusion of social determinants'. Likewise, Wilkinson and Marmot's work is cited in footnotes in several of Farmer's publications (e.g., Farmer 2004, 2005), in support of statements regarding the effects of inegalitarian social structures on the health of wealthier populations. However, intensive engagement is rare – although an exception occurs in Farmer's

(2001) book *Infections and Inequalities*, where he suggests that Wilkinson's focus on societies as nation states obscures those at the periphery of the global system, who effectively become 'invisible to those tallying the victims of modern inequality', despite the fact that they are 'casualties of the very same processes that have led to crime and decreased social cohesion "at home"' (Farmer, 2001, p. 281).

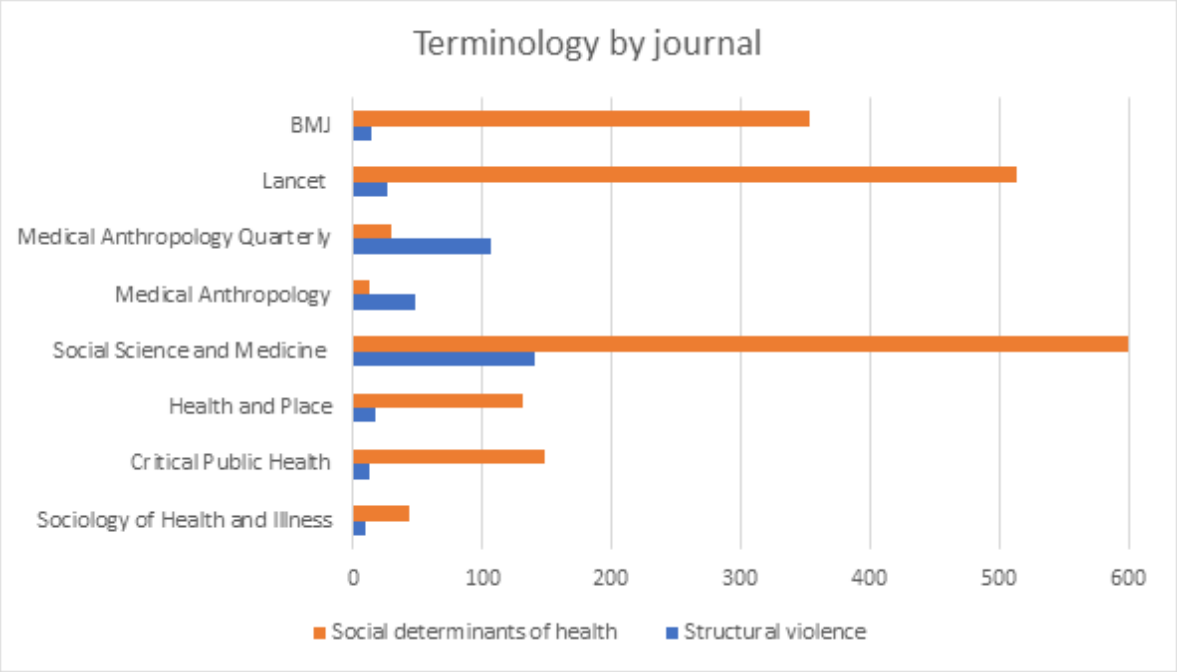

Figure 2. Results of PubMed keyword searches in September 2019 on 'structural violence' and 'social determinants of health' by journal

Despite occasional acknowledgement of the connections between them, the two concepts – and their accompanying literatures – have rarely intersected directly at a disciplinary level. The use of the term 'structural violence' in studies of health and medicine remains largely confined to the discipline of medical anthropology, where its use greatly outstrips the language of the 'social determinants of health' (see figure 2). In some respects, this reflects the distinct disciplinary purposes for which the concept of structural violence was deployed in the field of medical anthropology. The social determinants of health framework, on the other hand, arose in an interdisciplinary context – at the intersection of the fields of epidemiology, demography, sociology, social medicine and public health – as part of a broader conversation about health inequalities (see Bouchard *et al.*, 2015). However, this does not entirely explain the disjuncture. After all, structural violence was introduced (by both Galtung and Farmer) in an interdisciplinary context and is used widely outside the fields of health and medicine by scholars working in a variety of disciplines. Moreover, Farmer is not the only scholar to have 'introduced' the concept

to the field of health research – we count at least two other independent attempts to do so amongst critical public health scholars (e.g., Prior, 1989; Scott-Samuel, 2009; Scott-Samuel *et al.*, 2009).

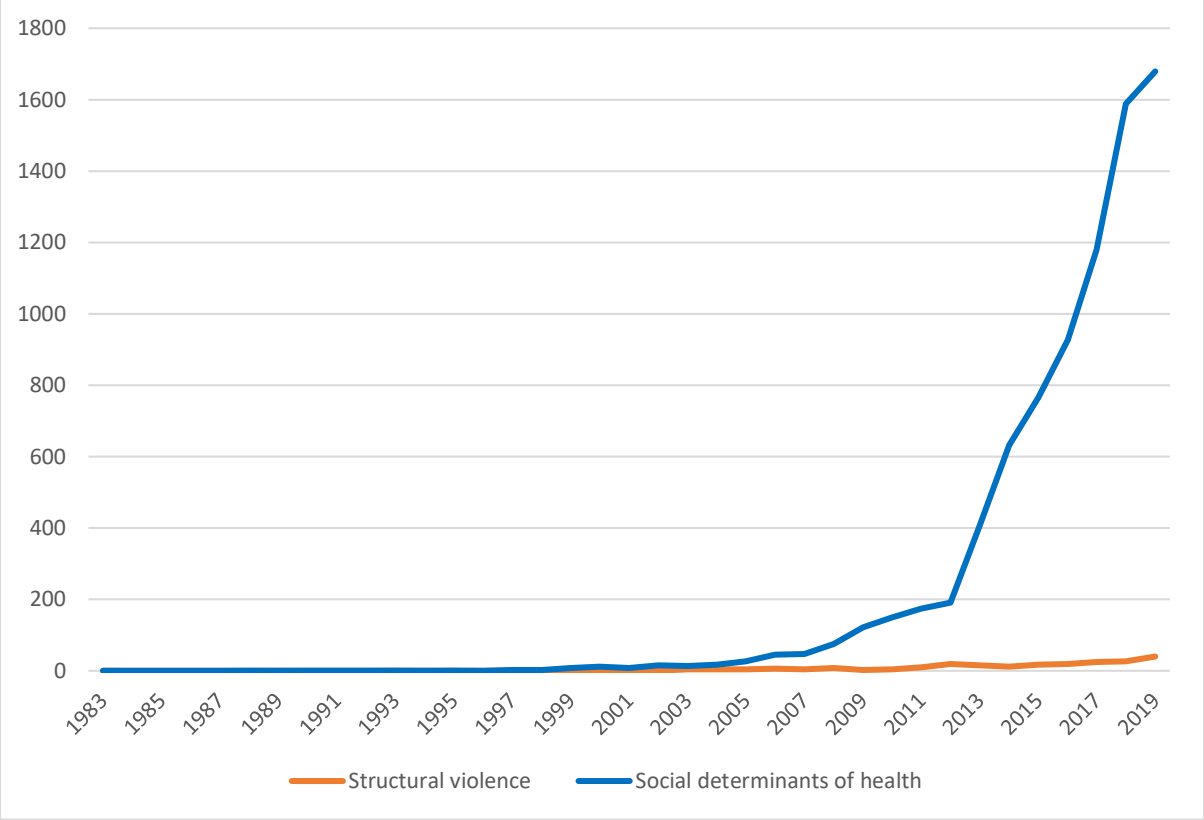

Figure 3. Citations for structural violence and the social determinants of health in PubMed as of September 2019

The relative ascendance of the social determinants of health (see figure 3) may, in part, be a consequence of the growing status of social epidemiology within the field of epidemiology itself. In many respects, the trajectory of the social determinants of health concept reflects the growing status of this subfield. It is also clearly connected with the methodological apparatuses underpinning the concepts of structural violence and the social determinants of health and the ways in which metrical forms of reason and truth-telling have displaced other forms of evidence (Adams, 2016; Adams *et al.*, 2019). Thus, the disciplinary siloing of the former concept potentially speaks to the uneasy relationship between medical anthropology and epidemiology (see Janes, 2017; Elliott & Thomas, 2017) – especially the difficulties of reconciling historical and qualitative analyses with positivist, quantitatively driven ones (see De Maio, 2010; De Maio & Ansell, 2018). As Janes (2017) observes of the early optimism surrounding the possibilities for

collaboration between anthropology and epidemiology, 'Ours was an intellectual, scholarly vision that in retrospect was naïve with regard to the social relations of science within the larger apparatus of what would become global public health' (p. 55).

Today, structural violence continues to be invoked primarily as an explanatory concept rather than a measurable phenomenon, although some efforts have been made to operationalise it (e.g., De Maio & Ansell, 2018). Thus, what is self-evident to anthropologists is seen by epidemiologists as lacking scientific support. In many respects, this speaks to a clash between the two disciplines' respective orientations to critical thinking. According to Janes (2017, p. 53), 'Epidemiologists are unwaveringly critical in their evaluation of evidence. Anthropologists are critical in their analysis of social relations of power'. Thus, epidemiologists demand evidence for precisely the things that anthropologists are trained to treat as given (see Elliott & Thomas, 2017). Indeed, Farmer castigates epidemiologists for the ways in which they 'take shelter behind "validated" methodologies while ignoring the larger forces and processes that determine why some people are sick while others are shielded from risk' – a characteristic, he suggests, that is more indicative of 'rigor mortis' than 'rigor' (2001, p. 181).

A final explanation for the differing disciplinary uptake of the two concepts is the role of terminology in reinforcing disciplinary boundaries, which, after all, are partly rhetorical in nature (Fuller, 1991). This tendency appears to be particularly pronounced in anthropology, given the discipline's oft-remarked upon 'boundary-controlling' and 'cocooning' orientation (see Eriksen, 2006; Lambert, 2009). As Dressler (2010) observes, despite the debate that Wilkinson and Marmot's work on the social determinants of health has generated, 'anthropologists have remained relatively mute in this discussion' (p. 552) – surprisingly so, given medical anthropologists' longstanding interest in the relationship between social inequalities and health. One culprit may be anthropologists' preference for 'anthropology-specific jargon and theoretically dense discourse' (Elliott & Thomas, 2017, p. 13). However, the two concepts under study are hardly unique in this respect. For example, Bouchard *et al.* (2015) have found disciplinary differences in the preferred terminology of researchers working in the field of health inequalities, with public health researchers, social epidemiologists and sociologists favouring the term 'inequalities', in contrast to the preference for 'disparities' in the fields of medicine, clinical epidemiology and health administration. They go on to observe that 'disparities' does not necessarily imply the presence of injustice in the way that 'inequalities' does, suggesting that they are not the synonyms they first appear (see also Dressler, 2010). Likewise, the differences

between structural violence and the social determinants of health clearly go beyond their contrasting orientation to evidence and their role in maintaining disciplinary boundaries.

What's in a name?

The variations in the dissemination, uptake and conceptualisation of structural violence and the social determinants of health speak to broad differences in the work they are intended to do. In the rare contexts where the social determinants of health and structural violence are explicitly compared, the latter is typically seen as superior in the ways it more explicitly calls out the violence of hierarchical power structures in creating and reproducing inequality. For example, Fassin (2004) suggests that structural violence does something more than introduce social determinants into the picture; it is more intrinsically powerful in its ability to link diseases – rhetorically at least – with social and political conditions. Likewise, according to De Maio and Ansell (2018, p. 750): 'in contrast to the more passive term "social determinants of health," structural violence explicitly identifies social, economic, and political systems as the causes of the causes of poor health'. They conclude that in its evocative framing of health inequalities as an act of violence, the concept adds something that terms like the social and structural determinants of health lack. Structural violence is thus a politically potent concept and its very use is always associated with an implicit or explicit critique of both the prevailing political order and the genesis of the status quo, although some accounts seem to assume that with 'a change of terminology alone... apathy will be transformed into action' (Herrick, 2019, p. 100).

The social determinants of health framework, on the other hand, has frequently been criticised for its *apoliticism*. For example, Navarro (2009) condemns the CSDH's *Closing the Gap* report for its 'studious avoidance of the category of power' (p. 440). This, he contends, 'reproduces a widely held practice in international agencies that speaks of policies without touching on politics... it is profoundly *apolitical* and therein lies the weakness of the report' (p. 440, emphasis added). For Navarro, 'It is not inequalities that kill, but those who benefit from the inequalities that kill' (*ibid*). The charge of apoliticism is curious given that the tradition of health inequality research has long been used as a powerful tool of political critique. It is thus perhaps more accurate to say that the report 'shies away from radical calls for social action to redistribute power, or any direct critique of neo-liberal economic systems' (Green, 2010, p. 2).

Recent critiques of the lack of tangible, global action on tackling the social determinants of health raise vital questions about the work that a concept or category can reasonably be expected to do

within (what can be) hostile political environments. This uncomfortable reality was predicted by the CSDH's original background document (Irwin & Scali, 2005), which drew detailed attention to the potential political roadblocks the Commission would face. In particular, the report highlighted the trade-off required between 'far-reaching structural critique... and promoting a number of tightly focused interventions that may produce short-term results, but risk leaving the deeper causes of avoidable suffering and health inequities untouched' (Irwin & Scali, 2005, p. 35). Indeed, structural violence has been criticised on precisely the opposite grounds: that its far-reaching structural critique generates more 'more moral heat than analytical light' (Wacquant, 2004, p. 322). Thus, if the social determinants of health framework speaks of policies without touching on power (to quote Navarro), structural violence speaks of power without touching on policy.

Structural violence has made relatively little inroads in influencing policies beyond HIV/AIDS and drug pricing – and it has not displaced the predominantly individualist, bio-technical orientation of interventions in the former field. This evident on the WHO and UN websites: 'structural violence' gains 3 search returns at the WHO and 87 at the UN, while 'social determinants of health' returns 1,387 hits at WHO and 488 at the UN. Interestingly, the impact of structural violence at the UN is more clearly within the domains of human rights, women, children and gender, despite Paul Farmer himself becoming United Deputy Special Envoy to Haiti in 2009 and a UN Special Advisor to the Secretary General on community-based medicine in 2012. While the SDH has a clear policy goal/target – the reduction of inequalities in morbidity and mortality, fronted by reference to social justice – the policy implications of structural violence remain constrained by its continued invocation as a narrative trope that sanctions the combination of general statements on possible causality with third person ethnographic accounts of dire life circumstances. As Lambert (2009, p. 19) observes, under the prevailing evidentiary regime, if medical anthropologists are to successfully contest 'what kinds of information constitute legitimate evidence for decision-making in public policy, then it is no longer sufficient to provide a deconstructive commentary without explicating the grounds for it'.

Recent rapprochements

Despite the relative invisibility of the concept of structural violence within the field of social epidemiology and anthropologists' comparable lack of engagement with the social determinants of health, there are some indications of a growing integration between these frameworks. In the field of social epidemiology, this is most evident amongst epidemiologists concerned with political economy, who have expressed considerable dissatisfaction with the 'social determinants of health' framework and its failure to call out the generative structural mechanisms that lead to health inequalities. As many critically-minded observers have noted, this inattention to structure has enabled the social determinants of health framework to be applied in reductive ways that bolster rather than challenge the lifestyle frame (e.g., Raphael, 2011; Krieger, 2011; Brassolotto *et al.*, 2014). The intensification of these debates has seen a new set of terms increasingly deployed, including 'societal determinants of health' and the 'structural determinants of health'. Notably, the CSDH also evidences this shift. Thus, while the *Closing the Gap* report made frequent mention of 'structural drivers', *A Conceptual Framework for Action on the Social Determinants of Health* (Solar & Irwin, 2010) gives new prominence to the concept of 'structural determinants' in defining the social determinants of health. To quote from the report, 'Together, context, structural mechanisms and the resultant socioeconomic position of individuals are "structural determinants" and in effect it is these determinants we refer to as the "social determinants of health inequities"' (Solar & Irwin, 2010, p. 6).

While 'structural determinants' seems to create a merger of sorts between the two concepts, the convergence appears to be accidental in much of the scholarship on this topic. For example, Krieger (2011) discusses efforts to repoliticise social epidemiological frameworks to ensure that structural determinants, rather than social position *per se*, are addressed. However, although she goes on to discuss Latin American social medicine – a key inspiration for Farmer's work – reference to structural violence is noticeably absent from the text itself. Likewise, although the CSDH's conceptual framework includes an extended discussion of power and makes reference to philosophical and political science literature on non-violent forms of 'structural oppression' (Solar & Irwin, 2010, p. 21), structural violence is once again absent.

Another area where a kind of merger seems to be occurring is in recent calls to attend to structural forces within medical practice. For example, echoing Farmer's critique of anthropology's adherence to cultural explanations, Metzl and Hansen (2014) argue that physicians must redefine cultural competency in structural terms. Advocating training in 'structural competency', they

suggest that this will 'address the complex relationships between clinical symptoms and social, political, and economic systems' (p. 127) – namely, the 'downstream implications of a number of upstream decisions' (p. 128). Despite the clear overtures to the social determinants of health in the language of 'upstream' and 'downstream' forces, neither Marmot or Wilkinson are cited in Metzl and Hansen's paper. Marmot and Farmer do finally meet in the 'Case Studies in Social Medicine' series of the *New England Journal of Medicine,* which has the stated aim of highlighting 'the importance of social concepts and context to clinical medicine'(Stonington *et al.*, 2018). The paper makes a number of similar points to Metzl and Hansen's earlier work on structural competency, although a key difference relates to the ways that the SDH framework is explicitly brought in. A passage from the paper is worth quoting at length to illustrate the nature of this rapprochement:

> Noncommunicable diseases... remain major global causes of illness and death, and their prevalence is increasing. The likelihood that these conditions and the prognoses and treatment outcomes associated with them will develop are strongly predicted by social factors, including income, race, ethnicity, immigration status, and place of residence: they cluster in social networks and are exacerbated by social inequalities. The fundamental causes of health and disease, however, are not these seemingly static characteristics that mark inequalities, but rather the social, political, and economic forces that drive these inequalities in the first place — *what we would call the structural determinants of the social determinants of health* (Stonington *et al.*, 2018, p. 1958, emphasis added).

Although the SDH is present within this rather convoluted definition, the paper more obviously gravitates towards a structural violence frame – perhaps unsurprising, given the anthropological credentials of the majority of the authors. The bottom line, as the authors make clear, is 'structural vulnerability', a term originally proposed by Quesada and colleagues in a heavily cited 2011 paper. In the *NEJM* series – which does not cite the original paper by Quesada *et al.* – 'structural violence' is defined as, 'the increased risk – for certain diseases, lack of access to care, or poor outcomes – caused by one's location in the social world as defined by the intersection of these large-scale forces' (Stonington *et al.*, 2018, p. 1959). In an echo of Farmer's early calls for attention to structural violence as an 'antidote' to anthropology's tendency to seek explanation in culture, 'structure' is argued to be a necessary 'conceptual antidote' to clinicians' tendencies to treat problems as the result of individual choices and residing in individual bodies (p. 1959). However, as Maani and Galea (2020) highlight, this call for growing medical engagement comes with its own problems: medical intervention in the field distracts from and absolves government, corporate actors and a plethora of other non-health policymakers from their responsibilities for affecting upstream change. Thus, while the social determinants of health and structural violence are now arguably coming together in more complex (and potentially convoluted) ways, there

clearly remains both great need and scope for integrating these approaches to formulate new types of awareness and foster new conversations about the multi-factorial drivers of health.

Conclusion

'Structural violence' and the 'social determinants of health' have been vital in drawing attention to the social, economic and political drivers of health inequalities and embodied experiences. As we have explored, structural violence was taken up as a key conceptual device within the field of medical anthropology and the social determinants of health has become critical to both public health and the field of social epidemiology. However, this paper shows that the disciplinary divergence and self-referentiality was never an inevitable or pre-ordained outcome. This points to the ways in which these concepts are intimately tied up with projects of disciplinarity themselves – with staking a certain kind of claim over concepts, using them for the purposes of internal critique (of culturalism in the case of structural violence, and of biomedical individualism in the case of the social determinants of health) – and their resultant value as both a conceptual shorthand and to signal a particular argument. Although the social determinants of health has been far more widely taken up, as we have shown, this is due a variety of factors, including its emergence *from* a body of evidence rather than preceding it, and the different evidentiary regimes in which the two concepts are embedded.

It is also worth noting that, fifteen years after the CSDH was first established, the World Health Organization has recently recommitted to the social determinants of health. A new Department of Social Determinants of Health was created in 2018 and the approach is included in the WHO's 13th General Programme of Work 2019-2023. Linking back to the original ambitions of the CSDH, a strategic meeting in late 2019 had, at its core, the task of 'strengthening the global narrative' and to re-define the WHO's work in this area to feed into a new strategic vision and set of priorities. We draw attention to this recent turn to illustrate just how central the narratives that underpin and accompany concepts are to their successful deployment in the volatile world of policy and politics. This is particularly important because neither structural violence or the social determinants of health have, thus far, done much to change the political or socio-economic *status quo* even if they have been influential in research and policy.

This lack of progress has been made painfully clear in recent months by the release of the *Marmot Review Ten Years on* (Marmot *et al.,* 2020). It shows how austerity has stalled any gains made on life expectancies in the UK and that these economic and social policies have also

undermined efforts to address the social determinants of health. In contrast to Navarro's earlier concern, the political critique here is clear and strong: the 'national government has not prioritised health inequalities, despite the concerning trends and there has been no national health inequalities strategy since 2010' (2020, p. 5). Echoing Farmer's language of structural violence – even if not directly citing him – the report has 'a greater emphasis on *poverty* as well as the socioeconomic gradient, those towards the bottom of the socioeconomic gradient have *suffered* particularly over the decade and require proportionately more investment and support... even just to bring them back to where they were in 2010 (*ibid,* emphasis added). Thus far, the global reality of ever-widening health inequalities does not seem to have exercised a strong enough pull to unify the social determinants of health and structural violence.

While Stonington *et al.*'s argument for the 'structural determinants of the social determinants of health' (2018, p. 1958) would seem to push the two concepts closer together, the nature of the integration remains superficial. Reconciling these frameworks requires genuine interdisciplinary dialogue, including a willingness to address the epistemological tensions between them (see De Maio, 2012). While this entails numerous challenges, it may suggest directions beyond the prevailing view that trade-offs are required between 'far-reaching structural critique' and 'tightly focused interventions' (Irwin & Scali, 2005, p. 35) and the resultant vacillation between these two positions. Without this rapprochement, changes in terminology – whether instigated by social epidemiologists or medical anthropologists – will do little to change these dynamics. Finding ways to both communicate this and the framework by which it can be researched should thus be at the heart of any future conceptual collusion.

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