highlighted the effect of an unfair global economic regime on health. This relation is also clearly articulated in the report of the WHO Commission on Social Determinants of Health.[2] Unfortunately, consideration of the political and economic determinants of health is absent from *The Lancet* Series.

A technocratic orientation pervades the Series, as exemplified by the definition of comprehensive primary health care. Rohde and colleagues[3] define comprehensiveness as a wide set of health-care interventions. However, our understanding is that it goes beyond interventions alone to include action in all domains, from prevention to treatment and rehabilitation, and incorporating behavioural, institutional, and social change.

The Series authors seem to assume that institutional reform takes place because policy experts and donors have identified the need and the necessary implementation mechanisms. However, many progressive health reforms (eg, in Thailand and Brazil) have been driven by the demands of civil society. Engaged community action on broader social determinants such as against water privatisation in Bolivia[4] or against seed privatisation in India[5] is a core element of the Alma-Ata vision.

For the **People's Health Movement website** see http://www.phmovement.org/

The People's Health Movement (in which we are all active participants) sees popular mobilisation as part of comprehensive primary health care and essential to addressing the social determinants of health. The People's Charter for Health, adopted in 2000, calls for popular mobilisation to "demand transformation of the World Trade Organisation and the global trading system so that it ceases to violate social, environmental, economic and health rights of people and begins to discriminate positively in favour of countries of the South". The need for such a transformation is shown by the current financial crisis, which illustrates the weaknesses of the current regime of global economic governance.

For the **People's Charter for Health** see http://www.phmovement.org/cms/en/resources/charters/peopleshealth

The Lancet Series presents a limited picture of primary health care, largely ignoring the challenges of engaging with cultural, economic, and political determinants of health. This is to be regretted.

We declare that we have no conflict of interest.

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Bias in WHO report on the social determinants of health

In your Nov 8 Editorial (Nov 8, p 1607),[1] you endorse the recommendations of WHO's Commission on Social Determinants of Health, thereby adding to the consensus that the report is a vital contribution to future health policy.

A respected peer-reviewed journal such as *The Lancet* should have been less hasty in giving its uncritical support to the WHO report, because it reinforces the misleading impression that it is an objective, academically rigorous examination of the relation between economic and social structures and health. It is not.

Although the report must be applauded for the wide range of topics it addresses, it presumes its conclusions and is highly selective with its evidence, giving it a lot in common with political propaganda.

There are a host of peer-reviewed studies in eminent journals that come to opposite conclusions about the usefulness of many of the Commission's proposals for domestic reform, including instituting minimum wage laws, beefing up welfare transfers, and tightening employment regulation.[2,3] Excessive government intervention in these areas has been shown to entrench unemployment and perpetuate poverty. How can that be good for health?

In the international sphere, the authors of the report have dwelled exclusively on the negatives of economic globalisation, implying that the myriad studies[3,4] showing a positive link between economic growth, free trade, human development, and health are not even worth a mention.

The failure to provide balance suggests a fundamental bias that cannot be excused in a report released under the auspices of a supposedly impartial body such as WHO.

I declare that I have no conflict of interest.

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Governments, civil society, and social determinants of health

In *The Lancet*'s special issue on social determinants of health, Erik Blas and colleagues (Nov 8, p 1684)[1] conclude that governments and civil society can have important positive roles in addressing health inequity if political will exists.

We believe that two issues deserve more attention. First, it is important to acknowledge that popular pressure from civil society is essential to ensure the necessary action by the state on social determinants. In 19th century Europe, for example, improvements in sanitation and general living conditions were in large part the state's response to the demands of the growing labour movement. Szreter[2] has argued that significant health improvements in Europe only began to appear when the increasing political voice and self-organisation of the growing urban population made itself heard, increasingly gaining actual voting power from the late 1860s onwards.

Second, neither the state nor civil society is a monolithic bloc. Navarro[3] has explained that class (and race and gender) power relations shape both civil and political society and are therefore the key determinants of power in a society. If we are to follow the call of the Commission on Social Determinants of Health to tackle the inequitable distribution of power, money, and resources,[4] we will have to be aware of contradicting interests and power relations within civil society as well as within the state.

Addressing the social determinants of health is not just a question of action by the state, civil society, or both. It is a matter of the most marginalised societal groups and classes, with the help of allies in civil and political society, organising and being able to influence power relations and pressuring the state into action.

We declare that we have no conflict of interest.

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Health-care equity—for all generations?

The report of the Commission on Social Determinants of Health (Nov 8, p 1661)[1] represents a formidable achievement. However, in a world where most older people live in the developing world, the prominent emphasis given to factors linked to inequity including gender, education, occupation, income, ethnicity, and place of residence, seems to miss out on the pervasive nature of ageism. Where later life figures in the full report, it is largely related to social protection issues such as pensions, but not to other forms of ageism which restrict access to a wide range of services including health care.[2] Even in disaster relief, older people suffer a disproportionate neglect.[3]

Is it possible that the Commission harbours reservations about the plasticity of old age, and the ability of older people to respond to a re-balancing of the social gradient? If so, such doubts should be dispelled by the remarkable improvement of the health and longevity of older people in East Germany when exposed to West German social, economic, and health supports.[4]

Although it is clearly a good principle to start early, with investment in early child development and education of girls and women, it is crucial that a lifespan developmental approach is taken to reviewing progress in reducing inequity of social determinants of health care, with particular emphasis on ensuring that older people have equity of access to services which benefit all, and gerontologically attuned services for age-related conditions.[5]

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Green space, psychological restoration, and telomere length

In his Comment (Nov 8, p 1614),[1] Terry Hartig explores the health-promoting properties of exposure to the natural environment, independent of socioeconomic factors. He points out that determining whether the effect is mediated through psychological restoration or increased physical activity could be difficult, in view of the paucity of data on psychological restoration compared with that for physical activity. We believe that our data on geographical variation in telomere length could contribute to answering this question.

Telomere length is affected by cumulative oxidative and inflammatory stress, having inverse associations with mortality, chronic diseases, and psychological stress,[2,3] and can be regarded as a marker of biological ageing. In a cohort study of the health status of 976 men aged 65 years and over from various regions in Hong Kong, we measured telomere length and examined its variation, adjusting for confounding