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Mental Health and Social Determinants: Their relationship with Public Policies. A brief analysis

Salud Mental y los Determinantes Sociales: Su relación con las Políticas Públicas. Un Análisis Breve

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Abstract:

This manuscript aims to briefly analyze the historical background of the health-disease process and its implications for the role of the individual in making healthy decisions. Initially, the understanding of this process positioned individuals as passive recipients of specialized medical knowledge and the recommendations or interventions necessary to achieve health. However, as knowledge has advanced, this perspective has evolved, as the material resources within health systems have not effectively reduced mortality rates in populations. Consequently, a contemporary view of individual agency has emerged. In this current perspective on physical and mental health, it is evident that contextual factors, such as social and material conditions, significantly influence individuals' choices regarding healthy behaviors.

Keywords:

Mental health, public policies, lifestyle, social determinants, health-disease process

Resumen:

El presente manuscrito tuvo como objetivo analizar de forma breve el recorrido histórico sobre el proceso salud-enfermedad y las implicaciones en el rol que ejerce el individuo para tomar decisiones saludables. Se observa como el propio entendimiento del proceso ha puesto en un primer momento al individuo como un ser expectante ante el conocimiento médico especializado y las recomendaciones o intervenciones necesarias para obtener la salud. Sin embargo, conforme ha avanzado el conocimiento esta perspectiva se ha visto superada pues los recursos materiales a nivel de sistemas de salud no han funcionado para disminuir la mortalidad en poblaciones. Es por eso por lo que ahora se ha optado por una visión de agencia individual. En esta perspectiva actual en la salud física y mental, se observa como las condiciones contextuales, como las sociales y materiales tienen gran influencia para que los individuos puedan elegir sus comportamientos saludables.

Palabras Clave:

Salud mental, políticas públicas, estilo de vida, determinantes sociales, proceso salud-enfermedad

INTRODUCTION

The World Health Organization[1] has established that mental health is a state that goes beyond the mere absence of a mental disorder, as well as physical health. It defines an integrative framework in which individuals can make decisions that are favorable to their well-being, build positive interpersonal relationships, and implement strategies that enable them to cope with stressful or distressing events in both their individual and social spheres. Furthermore, this state of mental health allows individuals to nurture themselves through personal and community growth.[2,3]

While this conceptualization of mental health is widely accepted, it is not without its issues. Although the focus of this essay is distinct from a discussion of the concept of mental health, it is worth to examine the journey that the conceptualization of health has undergone and to recognize that the components that now constitute this vision have been integrated in a piecemeal fashion.[4]

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This trajectory, like that of physical health, has evolved from a mono-causal and biological perspective toward an integration of material and social contexts, in which health results from the interaction between the individual and his environment and the resources and opportunities provided to them. These latter aspects are encompassed within the concept of social determinants, which influence how individuals develop within their environments and how these circumstances affect their health and susceptibility to disease.[5]

Discussing the social determinants of health, as outlined by Lalonde, serves to recognize the constant evolution of society and the challenges inherent to this progress. Seventy-five years ago, the World Health Organization[6] recognized that health is a complete state of physical, mental, and social well-being rather than merely the absence of disease or illness. Twenty-six years later, in 1976, the Canadian lawyer and minister published a series of policy proposals that illuminated and followed up on the international conference held in New York, emphasizing that health encompasses not only mental aspects but also significant social dimensions.[7-9]

For this reason, reference the statements made in 2008 by the Commission on Social Determinants of Health and in 2011 in the Rio Political Declaration on Social Determinants of Health. Both documents assert that governance should shift toward a vision in which health and development conditions that impact on daily life are improved. This shift necessitates the implementation of public strategies such as health policies, that also address the unequal distribution of power, money, and resources, which are fundamental pillars of living conditions.[10,11]

CONCEPTUALIZATION OF HEALTH AND ITS IMPLICATIONS

Based on Table 1, discussing the temporal aspects of the concept of health and its implications allows us to understand that the updates to this concept are relatively recent in the context of contemporary society. However, a simple analysis reveals the reasons for this. The initial conception of the health-disease process was rooted in divine explanations, where illness was viewed as a punishment for immoral acts. In contrast, during the 5th century, Hippocrates began to emphasize the importance of natural/biological causes of disease, and the influence of the environment on health.[9]

However, during the Middle Ages, the West experienced a stagnation in the proliferation of knowledge established by Hippocrates and other contemporary authors. In contrast, the Middle East began to recognize material principles that influenced health: pure air, moderation in eating and drinking, balance between rest and work, wakefulness and sleep, and emotional responses. Under these principles, it was proposed that tiny organisms in water or the atmosphere could produce diseases, and that these diseases could be explained by the characteristics of the individual and the environment.[12]

Europe's economic and cultural resurgence in the Modern Age allowed it to distance itself from the Church. The explanations of the health-disease process, along with the knowledge of Hippocrates (from antiquity) and insights from the Middle East (from the Middle Ages) were revisited with renewed vigor., This resurgence coincided with technological advances such as the microscope, which gave rise to microbiology which formalized the materialistic, physical, and biological interpretation of disease. However, this perspective still adhered to a mono-casual model, positing that disease is caused by an external agent that disrupts the organism.[13]

Table 1. *Brief historical overview of advances in health.*[9,12,13]

Historical Stage	Description
Old age	In ancient Greece, Hippocrates began the search for a rational explanation of diseases by considering their symptoms to formulate diagnoses and offer the most appropriate treatments. In Egypt and Mesopotamia, the earliest descriptions of diseases were recorded. In India, Ayurvedic medicine was developed.
Middle age	The concept of a hospital was created, a place where patients could be treated by physicians with specialized equipment. The Salernitana Medical School played a crucial role in transmitting medical knowledge.
Modern age	The true nature of the heartbeat and blood circulation was established. The invention of the microscope made it possible to investigate blood cells, spermatozoa, and even microbes. Important medical schools were founded.
Contemporary age	Penicillin, the first antibiotic, was discovered. The field of medicine was transformed by developing new techniques, technologies, and approaches, such as using cutting-edge technology. Artificial intelligence helped to predict the three-dimensional structure of proteins.

In this growing trend in Europe regarding the health-disease process, the medical police system was initiated to make the State responsible for the population's health. On the other hand, the impact of labor and socioeconomic conditions and their relationship with disease was recognized, which gave way to social medicine as a strategy for dealing with people's health problems. Between 1830 and 1851, a series of actions were taken to formalize the Public Health movement, which led to the need to improve the hygiene and housing conditions of the workers who migrated from the countryside to the city due to the industrialization that was taking place in France. The extreme

poverty in which the workers found themselves meant that the most common diseases were tuberculosis, pneumonia, measles, smallpox, and cholera, which can be recognized as diseases directly associated with the immediate material context.[14,15]

This stage of industrialization and the need to address working conditions were critical for the implementation of labor laws or policies that were already strategies directly focused on the safety and health of employees, so much so that we can already point to the emergence of social security, as a series of guidelines that take care of the worker during his working hours, disability, and family. Starting, of course, from the fact that the conditions in which they lived forced them not to stop working despite being injured or sick since their livelihoods depended on each day they worked. Moreover, this is a conditioning aspect of health and illness.[14,16]

However, the rise of the mono-casual biological process diminished proposals by physicians, economists, politicians, and even philosophers that pointed to a health-disease relationship and sociopolitical context. It also brought with it a vast knowledge of the biological substratum of disease as processes began to be understood at the level of organs, cells, tissues, and biochemical components of the human organism, both the healthy and the sick individual. Likewise, scientists acquired chemical and physical resources that favored diagnosis and treatment. On the other hand, genetic progress allowed the medical field to interpret, treat, and manipulate some diseases. It is important that since there was such an established paradigm and a transparent object of study, the multiple actions saw surprising results, which already began moving the population away from infectious diseases.[17]

At this point, mono-causal and multicausal variables coexist in the field of health. However, the biomedical model has predominated due to the needs that have arisen. However, the critical analysis carried out throughout history by various authors has focused attention on a vision that encompasses micro and macro levels that could point to an ecological model of the health-disease process to understand that although there are triggering variables, there are others that potentiate or mitigate the effect of stimuli or pathogenic behaviors.[18,19]

With time, infectious diseases influenced mainly by unhealthy environmental factors decreased considerably, and even some eradicated from some population contexts; however, mortality is a variant that is still present, attracting the attention of epidemiologists and health personnel.[20] In other words, the question remains: what type of populations continue to be primarily affected by infectious diseases? The answer may follow along the lines of the material resources or living conditions to which someone is exposed or to which they can aspire to the main reason.

A NEW UNDERSTANDING OF HEALTH

In 1974, Marc Lalonde published his report on New Perspectives on the Health of Canadians, in which he adopted a broader vision of the health-disease process, involving aspects of human biology, the environment, lifestyle, and the organization of health care at the institutional level.[21]

This postulate lays the foundations for health promotion and disease prevention. It first recognizes that at an economic level, it allocated a large amount of resources to the institutional organization in health, which implied detecting, curing, or alleviating health problems; however, the numbers were not lower in mortality. At this point, analyses show that mortality is influenced by the states' lifestyles therefore less attention and resources are paid to it.[22]

The problem was mainly that the cost of health care and services increased, but this was not directly related to the improvement in the health of the population, i.e., there was no increase in the number of healthy people or decrease in disease. Therefore, a new space is given to lifestyles based on the relationship between investment and the influence on mortality, moving away from a purely biomedical model. This space focuses the intervention on informing people on how they can or should take care of their health so that they, in turn, make decisions that will lead them to healthy habits.[4]

Although Lalonde's report in 1976 is one of the most emblematic documents on the determinants of health, this vision was already being discussed in countries such as England, Germany, the United States, and even Latin America, where, since the eighteenth century, the importance of poverty and the policies surrounding it that could impact on the health of the population was mentioned. In addition, these visions not only play the role of understanding the health-disease process from the elements in which the person developed, but they are also a critique of the political system, which, through the established structures, maintains social problems such as inequality, which generate physical and mental discomfort.[23-26]

The rise of the healthy lifestyles model recognizes the agency of people to operate in terms of their health[27], based on knowledge; however, just as in the beginning, institutional medical care had the most significant weight in the health-disease process, it seems that over time now the individual responsibility began to be the central axis of getting sick, without considering that the person is still subject to a specific context that enables or hinders knowing and acting in favor of health.[28]

Based on the above, Dahlgren and Whitehead[29] 30 years ago built a model that exemplifies this subject-context relationship, in which individual variables of people influence their health, which in turn are conditioned by their lifestyles, which are also related to the social and community networks in which they find themselves, and which are also influenced by the living and working conditions that are ultimately under the order of socioeconomic, cultural and environmental conditions.

Figure 1 shows that this model is structured in layers, where a higher layer influences each condition while related to a previous layer. Under this conception, health strategies that only consider one of the levels have less capacity to impact compared to those that focus on several levels.

The model[29] allows us to visualize that although the most significant health burden is related to the actions and decisions taken for well-being, this lifestyle choice is conditioned by the options one may have, i.e., it is not the same to opt for a healthy life when one has education, adequate economic income and lives in a safe neighborhood, as when one has minimal income, no education and limited access to essential services. Therefore, the paradigm of the health-disease process is expanded, where the loss of health is related to social inequalities rather than agency and choices, which are not only notorious in terms of extremes, i.e., poor vs. rich but, even in people with average resources and options, inequality also exists.

Figure 1. Dahlgren and Whitehead's Model of Social Determinants.[29]

In their report "*Social Determinants of Health. The Proven Facts*" social epidemiologists Wilkinson and Marmot[30] identify ten social factors that have an impact comparable to variables such as obesity, tobacco, and alcohol consumption. These factors include social slope, stress, early life, social exclusion, work, unemployment, social support, addictions, and diet. This perspective is considered the determinants or conditions behind the fields mentioned by Lalonde in 1974 and is related to Dahlgren and Whitehead's model in 1991.

Thus, the situations in which one is born, grow, and develop are subject to how economic and material resources are distributed. It impacts the conditions of inequality that permeate the population's health. For example, authors such as Hart[31] postulate that the availability of medical care moves inversely to the needs of the population, i.e., better health services are accessible to people who can pay for them. However, this segment of the population does not necessarily need them most since the very conditions in which they develop make them less vulnerable to pathogens or risky behaviors. On the other hand, people with more significant deprivation and fewer needs require greater attention because they are more susceptible to illness due to the lifestyle to which they are disposed, which, in addition, limits them from seeking adequate health care.

It is also recognized that conditions such as social class, gender, age, ethnicity, and territory exert an influence of power within the population where some benefit more than others so that these inequalities are maintained.[32]

Therefore, Mexico and all of Latin America are no strangers to being guided by a social-political vision on the attention to existing health problems since it is precisely in these places that inequalities exceed a biomedical care model and hinder a model of agency that makes the subject responsible for their health.[17]

In recent years, political management has attempted to impact those social determinants that influence health aiming to reduce gaps or inequalities in this field through targeted interventions in vulnerable groups and marginalized communities, but these objectives have remained developmental policies. Although various programs aim to provide individuals living in extreme poverty with additional government income to support essential areas like nutrition, this strategy was incomplete because within the chain and dynamics of inequalities, only one link was covered and there was a lack of connection with other determinants. This strategy was incomplete because within the chain and dynamics of inequalities, only one link was covered, and there was a lack of connection with other determinants, i.e., although money is vital in this capitalist system in which the country and each of the individuals who inhabit it find themselves, money must have an integral impact. That is to say. It must be helpful to improve the overall quality of life in the future, since it alone will not be enough, since there will be no opportunities if the people living in extreme poverty are in places with a lack of essential services, if the schools are hours away, if the neighborhood where they live is unsafe or if there is no employment, among others. Therefore, the greatest challenge is the need for articulation between strategies at the different levels of intervention, as stated in the social determinants.[33]

INTEGRATION OF SOCIAL DETERMINANTS IN HEALTH

By 2024, the year this manuscript was written, the National Development Plan 2019-2024[34] is being implemented, establishing a series of social and political objectives to build a country with well-being. Within the plan, a series of programs for development and social welfare that impact the population's health are contemplated.

Most of the plans coincide in providing economic support, under the concept that the lack of such support is the main reason for the malaise and social symptoms. However, under the model of social determinants and structures of inequality, economic deprivation results from social inequalities, which in turn maintain and aggravate the disparity, thus creating a vicious circle. On the other hand, as mentioned, few programs visualize an interrelation between social determinants.[35,36]

Table 2. Those plans that explicitly contemplate the integration of social determinants for public policies can be observed.

MENTAL HEALTH CONSIDERATIONS

Currently, thinking about mental health and illness does not mean considering the presence of clinically relevant disorders diagnosed using a manual, such as ICD-10[37] or DSM-V[38], but

also those situations that incapacitate the person due to the intensity of psychosocial or emotional distress, which can translate into a perception of considerable anguish, functional disability, or risk of self-injurious behavior.[37,39] A clear example of this paradigm shift is the feminist vision regarding mental health in women, as it has brought to the table aspects that are exclusive to the condition of being a woman, such as menstruation and its related conditions, which incapacitate women from being productive and being able to solve themselves, which has psychosocial repercussions since a woman who has high stress due to an illness that limits her productive activity will be involved in a downward spiral where the previous condition generates more and more stress.

Table 2. *Specific Action Programs that consider Social Determinants*. [35,36]

Specific Action Program	Description
On healthy environment and communities 2013-2018	- Encourage communities and environments to be hygienic, safe, and conducive to better health. - Encourage municipalities to comprehensively address the determinants that influence the population's health status. - Strengthen the competencies of health personnel and the different social actors in the community and the municipality. - Strengthen monitoring and evaluation mechanisms to increase the Program's effectiveness.
Health Promotion and Social Determinants 2013-2018	- Deliver health promotion services with a focus on health determinants. - Strengthen health promotion in comprehensive lifeline care. - Develop knowledge, skills, and attitudes to manage adequately health determinants. - To favor the incorporation of healthy public policies in public, social, and private services. - Generate habits and behaviors favorable to health. Based on the principles of health social marketing. . - Strengthen monitoring and evaluation mechanisms to increase the Program's effectiveness.

Therefore, it would not speak of a deficiency in their mental health but the lack of attention by Public Health to provide tools and strategies to women with these conditions.[40]

The above is related to the general vision in this manuscript, which is based on a contextual vision in which mental health depends more on the social conditions in which one lives than on a psychological or even biological "marker" that affects mental health. Moreover, it is also necessary to recognize that from a purely psychological point of view, human suffering and pain are part of life. It is part of existence, however, noting, for example, the alarming figures of mental disorders speak of suffering that perhaps goes beyond the expected. However, there is a systematic neglect of the political system that justly continues without solving people's daily lives and facilitating their individual and social development.[41,42]

The most common conditions that have an impact on mental health are anxiety and depression, as shown in Table 3. In 2020, it was recorded that they increased between 26% and 28% due to the COVID-19 pandemic.[1,43] In addition, although there are scenarios for preventing and treating these ailments, people do not have access to timely and effective intervention; in addition, children are the most vulnerable and continue to present sequelae for the year in writing this manuscript began. In 2019, 301 million people around the world suffered from an anxiety disorder, of which 58 million were children and adolescents; on the other hand, depression affected 280 million people, among whom 23 million were children and adolescents.[44]

Table 3. *Mental disorder statistics in 2019 according to WHO.*[44]

Mental Disorder	Statistics
Anxiety	301 million people suffered from anxiety, including 58 million children and adolescents.
Depression	280 million people suffered from depression, including 23 million children and adolescents.
Bipolar	40 million people suffered.
Schizophrenia	It affects an estimated 24 million people or one in 300 people.
Eating behavior	14 million people suffered from eating disorders, of whom almost 3 million were children and adolescents.
Disruptive and dissocial behavior	40 million people, including children and adolescents, suffered from dissocial behavior disorder.

Both anxiety and depressive disorders are characterized by an intense emotional reaction, the former by an excessive burden of worry, fear, and danger, the latter by a perception of emptiness, meaninglessness, and hopelessness. Although the etiology of these problems is multifactorial, a vital vulnerability is recognized in adolescents due to their stage of development, which is characterized by a greater emotional reactivity to life events. It implies that the loss (or the possibility) of an important person, such as a friend, family member, or partner, can trigger a series of unhealthy behaviors that put their or others at risk.[37,38]

In general, it has been recognized that some risk factors for mental health loss are lack of emotional skills, substance abuse, genetics, poverty, violence, inequality, adverse environmental circumstances, rigid and punishing parenting styles, and bullying, among others, and on the other hand, some protective

factors to prevent mental health loss may be the development of individual emotional skills, positive social interactions, quality education, teachers' work, safe communities, social cohesion, among others.[45,46]

It is essential to stop at this point and, without pretending to sound too malicious, present the intention of this essay: to ask whether it is possible to talk about a Public Health problem because the statistics say that people are staying sick and dying or that the economic cost is exceeding the budget without apparent gains. At first glance, the two visions are not necessarily contrary; however, as has been said, all subjects live in a context, and the public service, in turn, is also immersed in a more extensive economic and political system. One is to ask whether the capitalist structure pulled the strings in seeking to improve the health system.

It is then recognized that although people have agency in their health care, healthy lifestyles are conditioned by society, gender, age, ethnicity, and territory inequities. Thus, a new perspective emerges to address the problems of Public Health, highlighting the systematic neglect of vulnerable populations, such as children, through power structures that prioritize segments of the population that are profitable to maintain. It also highlights those aspects associated with *education, public health policies, health, community infrastructure, and local economic development* that must achieve an interconnection that favors a bridge for the entire population, reducing inequalities as much as possible.

Each aspect of public health is a crucial link that impacts population's well-being. It is acknowledged that various programs in the country attempt to address these aspects. However, the lack of integration and disconnection between these actions create a vicious cycle that endures health problems. It highlights the urgent need for a more comprehensive and integrated approach. Understanding that physical and mental health cannot thrive without adequate social conditions is relevant. These conditions extend beyond economic resources and must address people's fundamental needs, providing resources that create opportunities.[47-49]

CONCLUSIONS

Therefore, reflection must reinforce a broader vision of health, considering the interaction of the determinants of life and health and moving away from normative and stigmatizing criteria. It implies rethinking the health concept and going beyond the WHO definition, considering mental health as a combination of material and cultural aspects, which condition and limit the individual and access to health care. Finally, mental health should be considered a pillar of universal health coverage, bearing in mind the material, scientific, academic, and innovative aspects.

REFERENCES

[1] Organización Mundial de la Salud [Internet]. Salud Mental: Fortalecer nuestra respuesta, Organización Mundial de la Salud. 2022 – [cited 2024 feb 7]. Available from: https://www.who.int/es/news-room/fact-sheets/detail/mental-health-strengthening-our-response.

[2] Organización Mundial de la Salud [Internet]. La OMS mantiene su firme compromiso con los principios establecidos en el preámbulo de la Constitución. Organización Mundial de la Salud. 2024 – [cited 2024 feb 25]. Available from: https://www.who.int/es/about/governance/constitution

[3] Westerhof GJ, Keyes CLM. Mental Illness and Mental Health: The two continua Model Across the Lifespan. J. Adult Dev. 2010; 17(2): 110-9.

[4] Hernández-Paz MTJ, De la Torre-Herrera JN, Espinoza-Gómez MC, Lara-García B, Gutiérrez-Cruz S. El concepto de salud mental desde la visión del Estado mexicano. Rev. Educ. Desa. 2016; 37: 89-93.

[5] Waitzkin H. The social origins of illness: a neglected history. Int. J. Health Serv. 1981; 11(1): 77-103.

[6] Organización Mundial de la Salud [Internet]. El Abordaje de los Determinantes Sociales de la Salud a través de acciones intersectoriales: cinco casos de política pública de México. Organización Mundial de la Salud. 2013 – [cited 2024 feb 28] Available from: http://iris.paho.org/xmlui/handle/123456789/6291.

[7] Hernández LJ, Ocampo J, Ríos DS, Calderón C. El modelo de la OMS como orientador en la salud pública a partir de los determinantes sociales. Rev. Salud Pública 2017; 19(3): 393-5.

[8] Lalonde M. Perspectives from PAHO public health heroes. Pan. Am. J. Public Health 2002; 12(3): 149-52.

[9] De La Guardia Gutiérrez MA, Ruvalcaba Ledezma JC. Health and its determinants, health promotion and health education. JONNPR 2020; 5(1): 81-90.

[10] Jackson B, Huston P. Advancing health equity to improve health: the time is now. Health Promot. Chronic Dis. Prev. Can. 2016; 36(2): 17–20.

[11] Valadez Figueroa I, Villaseñor Farías M, Alfaro Alfaro N. Educación para la Salud: la importancia del concepto. Rev. Educ. Desa. 2004; (1): 43-8.

[12] Alotaibi HHS. A Review on the Development of Healthcare Infrastructure Through the History of Islamic Civilization. J. Healthc. Leadersh. 2021; 13: 139-45.

[13] Parafita D [Internet]. Recorrido histórico sobre las concepciones de salud y enfermedad. Área de Salud, curso Niveles de Atención en Salud. Facultad de Psicología. 2010 – [cited 2024 feb 22]. Available from: https://psico.edu.uy/sites/default/files/cursos/nas_ficharecorridohistoricodelasconcepcionesdeSE1.pdf.

[14] Navarro Ruvalcaba MA. Modelos y regímenes de bienestar social en una perspectiva comparativa: Europa, Estados Unidos y América Latina. Desacatos Rev. Antropol. Soc. 2006; 21: 109-34.

[15] Pérez CM. Los paradigmas médicos: factores de su conservación y cambio. In: Pérez CM, Lecturas de filosofía, salud y sociedad. (1st ed). La Habana: Editorial Ciencias Médicas 2000: 57-62.

[16] Segui-Gómez M, Toledo AE, Jiménez-Moleón J. Sistemas de Salud. Modelos. In: Martínez MA, editor. Conceptos de Salud Pública y Estrategias Preventivas. Un Manual para ciencias de la salud. (1st ed). Barcelona: Elsevier Health Sciences 2013: 419-24.

[17] Baeta MF. Cultura y modelo biomédico: reflexiones en el proceso de salud enfermedad. Comunidad y Salud 2015; 13(2): 81-4.

[18] Álvarez Castaño LS. Los determinantes sociales de la salud: más allá de los factores de riesgo. Rev. Ger. Pol. Sal. 2009; 8(17): 69-79.

[19] Hernández-Girón C, Orozco-Núñez E, Arredondo-López A. Modelos conceptuales y paradigmas en salud pública. Rev. Salud Pública 2012; 14: 315-24.

[20] Sánchez-González MA. Historia y futuro de las pandemias. Rev. Med. Clin. Condes 2021; 32(1): 7-13.

[21] Laframboise HL. Health policy: breaking the problem down into more manageable segments. Can. Med. Assoc. J. 1973; 108(3): 388-91.

[22] Dever GEA. An epidemiological model for health policy analysis. Soc. Indic. Res. 1976; (2): 453-66.

[23] Engels F. The condition of the working class in England. Am. J. Public Health 2003; 93(8): 1246-9.

[24] Virchow RC. Report on the typhus epidemic in Upper Silesia. 1848. Am. J. Public Health 2006; 96(12): 2102-5.

[25] Medina-De la Garza Carlos E, Koschwitz MC. Johann Peter Frank y la medicina social. RMU 2011; 13(52): 163-8.

[26] Winkelstein W. Lemuel Shattuck: architect of American public health. Epidemiology 2008; 19(4): 634.

[27] Pastor Y, Balaguer I, García-Merita ML. Una Revisión Sobre Las Variables De Estilos de Vida Saludables. PSSA 1998; 10(1): 15-52.

[28] Arcaya MC, Tucker-Seeley RD, Kim R, Schnake-Mahl A, So M, Subramanian SV. Research on neighborhood effects on health in the United States: A systematic review of study characteristics. Soc. Sci. Med. 2016; 168: 16-29.

[29] Dahlgren G, Whitehead M. The Dahlgren-Whitehead model of health determinants: 30 years on and still chasing rainbows. Public Health 2021; 199: 20-4.

[30] Wilkinson R, Marmot M [Internet]. Los determinantes sociales de la Salud. Los hechos probados, Organización Mundial de la Salud. 2010 – [cited 2024 feb 22]. Available from: https://recs.es/wp-content/uploads/2017/06/hechosProbados.pdf.

[31] Hart JT. The inverse care law. Lancet 1971. 27; 1(7696): 405-12.

[32] Solar O, Irwin A [Internet]. A conceptual framework for action on the social determinants of health, Organización Mundial de la Salud. 2010 – [cited 2024 feb 20]. Available from: https://www.who.int/publications/i/item/9789241500852.

[33] Reyes-Morales H, Dreser-Manilla A, Arredondo-López A, Bautistas-Arredondo S, Ávila-Burfos L. Análisis y reflexiones sobre la iniciativa de reforma a la Ley General de Salud de México. Salud Pública Mex. 2019; 61(5): 685-91.

[34] Gobierno de México [Internet]. Plan Nacional de Desarrollo 2019 – 2024, Gobierno de México. 2019 – [cited 2024 April 10]. Available from: https://framework-gb.cdn.gob.mx/landing/documentos/PND.pdf.

[35] Secretaria de Salud [Internet]. Entornos y Comunidades Saludables 2013-2018, Secretaria de la Salud. 2013 – [cited 2024 april 5]. Available from: https://www.ssch.gob.mx/rendicionCuentas/archivos/Promocion%20de%20la%20Salud%20y%20Determinantes%20Sociales.pdf.

[36] Secretaria de Salud [Internet]. Promoción de la Salud y Determinantes Sociales 2013-2018, Secretaria de la Salud. 2013 – [cited 2024 april 5]. Available from: https://drive.google.com/file/d/0B0K9c-Z-JA2nWTltVGJMeFN5cFU/view?resourcekey=0-GCj7xtm9WNGWCZiv7IUEXw.

[37] Organización Mundial de la Salud. Clasificación Internacional de Enfermedades, undécima revisión (CIE-10). Washington DC: Panamericana; 2019.

[38] American Psychiatric Association. DSM-5: Manual diagnóstico y estadístico de los trastornos mentales. Washington DC: Panamericana; 2014.

[39] Berenzon S, Lara MA, Robles R, Medina-Mora ME. Depresión: estado del conocimiento y la necesidad de políticas públicas y planes de acción en México. Salud Pública Mex. 2013; 55(1): 74-80.

[40] Ramos-Lira L. ¿Por qué hablar de género y salud mental? Salud Ment. 2014; 37(4): 275-81.

[41] Miranda Hiriart G. ¿De qué hablamos cuando hablamos de salud mental? Utopía y Prax. Latinoam. 2018; 23(83): 86-95.

[42] Macías MJ, Valero AL. Mas allá del síntoma y el DSM. In: Macías MJ, Valero AL. Fundamentos y aplicaciones clínicas de FACT. Una intervención para abordar el sufrimiento humano a través de las terapias contextuales. España: Ediciones PIRÁMIDE; 2021: 15-21.

[43] Palacio-Ortiz JD, Londoño-Herrera JP, Nanclares-Márquez A, Robledo Rengifo P, Quinetero-Cadavid CP. Psychiatric disorders in children and adolescents during the COVID-19 pandemic. Rev. Colomb. Psiquiatr. (Engl. Ed.) 2020; 49(4): 279-88.

[44] Organización Mundial de la Salud [Internet]. Trastornos mentales, Organización Mundial de la Salud. 2022 – [cited 2024 feb 16]. Available from: https://www.who.int/es/news-room/fact-sheets/detail/mental-disorders.

[45] Lund C, Brooke-Sumner C, Baingana F, Baron EC, Breuer E, Chandra P, et. al. Social determinants of mental disorders and the Sustainable Development Goals: a systematic review of reviews. Lancet Psychiatry 2018; 5(4): 357-69.

[46] Quitian RA, Ariza CG. Los factores psicosociales y su relación con las enfermedades mentales. GPT 2015; 8(24): 30-7.

[47] De la Guardia MA, Ruvalcaba JC. La salud y sus determinantes, promoción de la salud y educación sanitaria. JONNPR 2020; 5(1): 81-90.

[48] Ávila-Agüero ML. Hacia una nueva Salud Pública: determinantes de la Salud. AMC 2009; 51(2): 71-3.

[49] Schrecker T, Labonté R, De Vogli R. Globalisation and health: the need for a global vision. Lancet 2008; 8372(9650): 1670-6.

[50] Svalastog AL, Donev D, Jahren Kristoffersen N, Gajović S. Concepts and definitions of health and health-related values in the knowledge landscapes of the digital society. Croat. Med. J. 2017; 58(6): 431-5.

[51] Gómez Arias RD. ¿Qué se ha entendido por salud y enfermedad? Rev. Fac. Nac. Salud Pública 2018; (36): 64-102.

[52] Patel V, Saxena S, Lund C, Thornicroft G, Baingana F, Bolton P, et al. The Lancet Commission on global mental health and sustainable development. Lancet 2018; 392(10157): 1553-98.