Speaking for Ourselves

The Commission on Social Determinants of Health: Mainstreaming social inequalities in public health education in India

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The final report of the Commission on Social Determinants of Health (SDH) has been the subject of analysis and policy discussions since its release in August 2008. Keeping in mind some of the early reviews of this report, the time has come to evaluate the pathways, both academic and political, that need to be mobilized to address this report in its fullest measure. As the dissemination of the report enters a new phase, its interpretation and reception in diverse policy arenas gains in importance, and its prioritization by key state and non-state agencies will need to be critically mapped and advocated in the near future. To address this, we need to recapitulate the strengths and implications of the report, as well as its national pathways.[1]

The report focuses on the importance of achieving health equity at a time when inequalities have increased within and across countries. Several western European countries, Canada and even the US have expressed concern over the rising inequalities in health. Among the developing countries, economic liberalization over the past 3 decades has impacted socioeconomic and health opportunities differentially across regions and social groups. While the upper middle classes have clearly benefited from the twin processes of globalization and liberalization, other sections of the middle class and the organized and unorganized working classes have not benefited to a similar degree. Given the variations in the levels of inequality within and across countries, this report reaffirms the need to acknowledge the relationship between society and health, and upholds the principles of social justice. It states that the 'commission's vision is a world in which all people have the freedom to lead lives they have reason to value. This is a matter of social justice. Health and its key determinants are an issue of human rights. Politically, it is vital, as the success of a society can be judged from the quality and fair distribution of its population's health'.[2]

As a first step towards achieving equity in health, the commission offers a conceptual framework drawn on the basis of a review of the theoretical frameworks that have informed this area of inquiry. In addition, it has commissioned papers on nine themes—early child development, globalization, employment conditions, social exclusion, health systems, priority public health conditions, measurement and evidence, women and gender equity, and the urban setting. These nine themes are called the knowledge networks and under each of them there is a position paper that reviews the existing literature and also offers suggestions.[3]

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A central concern of the report is to map, understand and recommend pathways to address the impact of widening social inequalities on health outcomes. While India's commitment to addressing health inequalities and social justice has been long-standing, voiced in its constitutional principles and prioritized in its welfare policies, there is a need for a re-examination of its magnitude and characteristics. As for our understanding of health inequality and the pathways through which it affects populations, both nationally and across states, we are handicapped by a severe limitation of data.

It is critical that we view this report not simply as a reflection of 'global' perspectives and meta-recommendations for policy-making. It needs to be seen as a catalyst and opportunity to flag national priorities, and to deepen and clarify our understanding of the 'causes of causes' or social determinants and health. This can only be taken forward by mainstreaming this area and its values into the heart of public health teaching and policy-making.

The commission's report provides the public health community an opportunity to review the theoretical discourses and empirical work in other countries, and the value these could hold for India.

The report suggests some actions that can be taken by nation-states to reduce inequalities, on the basis of the evidence drawn from the knowledge networks and other relevant research. The recommendations are bound to generate a great deal of debate. However, agreement or disagreement with the recommendations should not deflect from the main issue at hand, which is to further our understanding of the causes of health inequalities. One of the major prerequisites for this is a change in the thrust of public health education in India. We can use the report to help us assess the extent to which social inequality finds a place in the existing curricula, and to explore strategies to reorient public health curricula and pedagogy, so that medical students may gain a better understanding of the interrelationship between social determinants and health. The report could form the basis for a realignment of courses in the preventive and social medicine departments of medical colleges, which constitute the largest and most influential category of trainers of public health personnel in India. The effort should not be limited to public health education; the subject of social inequality and health must become an integral part of the undergraduate and postgraduate medical courses as well.

A reorientation of public health education would not only strengthen academic programmes, but would also have a positive influence on the culture of medical practice. It would help produce socially sensitive physicians who are well informed and up to date with the current debates in public health. Instead of focusing excessively on behavioural modification at the individual level, doctors could make their practice more relevant by applying their understanding of the social context of health and ill health.

THEORETICAL CHALLENGES IN PUBLIC HEALTH

There has been a great deal of debate on the issue of revising the teaching of public health in India. Public health education curricula in India continue to be informed by an approach that adopts the cultural and behavioural explanatory model, which assumes that the individual is responsible for his or her ill health. This model does not adequately spell out the pathways through which inequality and poverty impact on the health of populations. Thus, in general, there is a lack of emphasis on the structural factors that affect and shape individual behaviour. If we give importance to social structural processes, such as the relationship between health outcomes, on the one hand, and factors such as class, caste, gender and area on the other, we find that the reasons underlying health conditions go well beyond the individual to social groups. Some of these theoretical and conceptual debates are not sufficiently covered in our medical curricula.

The commission's report provides a synopsis of the recent debates on the concept of health being influenced by social determinants. It observes:

'The concept of SDH originated in a series of influential critiques published in the 1970s and early 1980s, which highlighted the limitations of health interventions oriented to the disease risks of individuals. Critics argued that understanding and enhancing health required a population focus, with research and policy action directed at the societies to which individuals belonged. A case was made for "refocusing upstream" from individual risk factors to the social patterns and structures that shape people's chances to be healthy. Integral to these critiques is the argument that medical care is not the main driver of people's health. Instead, the concept of social determinants is directed to the "factors which help people stay healthy, rather than the services that help people when they are ill".'[3]

One needs a theoretical framework that delineates the relationship between social determinants and health, as well as the processes involved, in order to make any meaningful analysis. In this context, the draft paper on the conceptual and methodological issues that informs the commission's report requires careful reading. It acknowledges the plurality of theoretical perspectives and summarizes the contribution of western European scholars, such as Marmot, Wilkinson, Dahlgren and Whitehead, Diderichsen and Hallqvist, and Mackenbach, in developing the concept of health being influenced by social inequalities. We have to focus on those aspects of their writing which can be generalized and are relevant in other contexts, such as the Indian context, if we are to make progress along the lines indicated in the report and its papers. The report holds that both structural and individual factors contribute to and sustain inequalities, but gives the former the status of a primary determinant, while the latter is seen as a secondary determinant. The two determinants are not seen as being independent of one another, but as interlinked. Elaborating on the nature of structural inequalities, the commission observes that:

'Health inequities reflect the unequal distribution of power, prestige and resources among groups in society. All societies are stratified along lines of ethnicity, race, gender, occupation, income and class … Stratification creates advantage and disadvantage across social groups. Progressive disadvantage can lead to marginalization and disproportionate vulnerability among those excluded from societal benefits. These processes of disempowerment can operate not only at the level of individuals, households, groups and communities, but also among countries and global regions.'[5]

The structural determinants are those that generate social stratification, and include the nature of the political system, the existing public policies, patterns of discrimination, distribution of power, governance, macroeconomic policies and social policies. It is the structural determinants that give rise to differences among social groups and influence their working and living conditions, which, in turn, have a direct impact on health outcomes. When people fall ill, their social position plays an important role in determining their access to health services and the quality of treatment that they are likely to receive.

Health services are an important intermediate determinant as their structure and accessibility or lack of accessibility can contribute to inequalities. However, the final report states clearly that the health services are only one of the channels for reducing inequalities and calls upon the government to play a major role in ensuring universality and equity. (For details *see* Chapter 9: Universal health care, pp. 94–106).

There will be much debate on this report and many differences have already emerged regarding its scope, methodology and recommendations. What is needed is an informed debate, both within and outside the public health community, on social determinants and health. The public health community, through forums such as the Indian Association of Public Health, can take the leadership in initiating a discussion on the recommendations, strengths and shortcomings of the report. It could also suggest ways to influence state and national policy, and encourage academic research in the sphere of social determinants and health. Advocacy for implementing the report's recommendations at the policy level is likely to come up against critical challenges, since changes in this area would require intersectoral coordination and multiple levels of policy engagement. Finally, though the report has been perceived as a call to arms, it is important to underscore its role as an impetus to re-examine the relationship between social determinants and health.

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