Course on Social Determinants on Health
Azim Premji University
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DISCOVERING THE 'SOCIAL (SOCIETAL) PARADIGM' IN HEALTH'?

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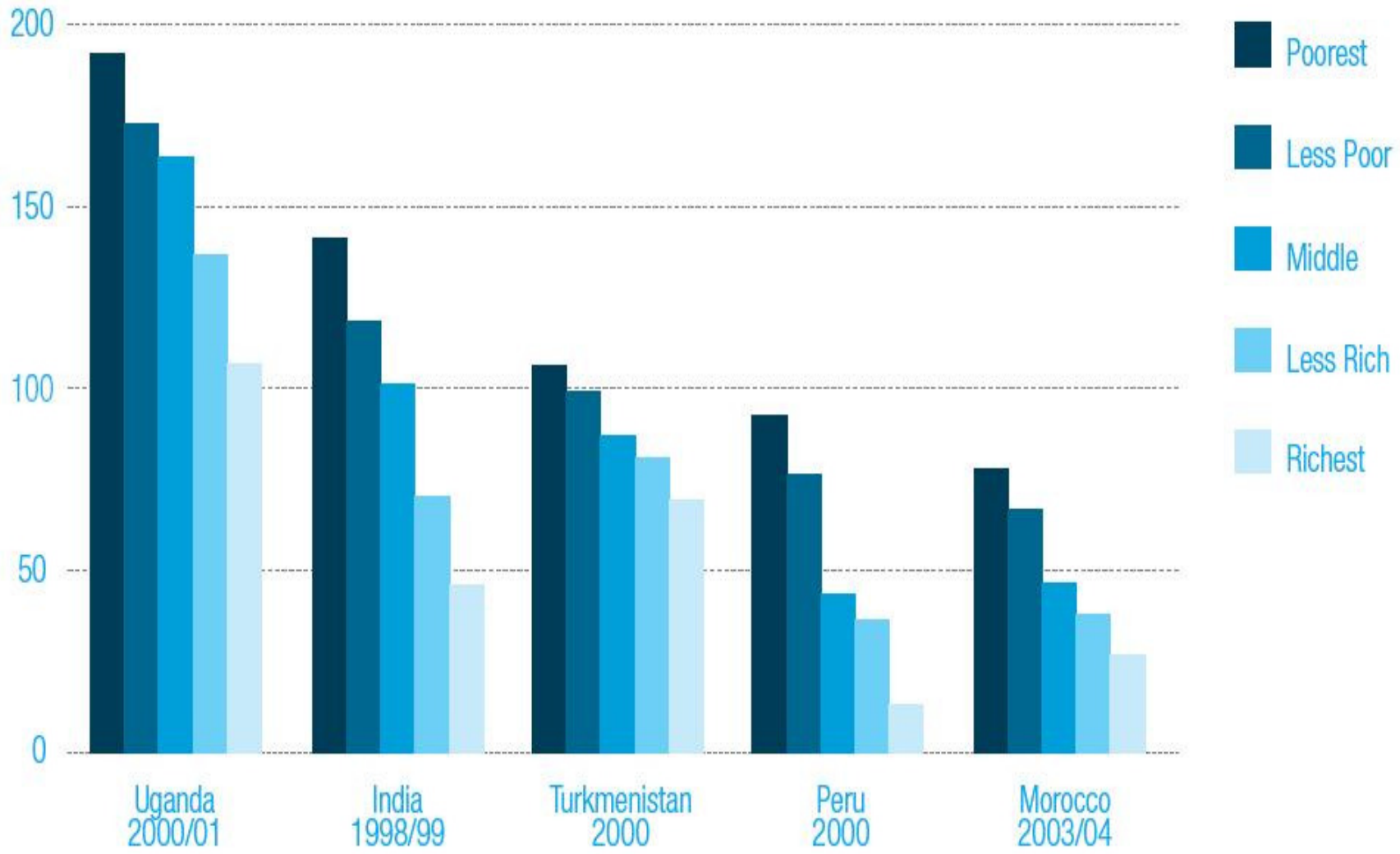
Social Determinants of Health - *A Quick Recap*

Place	Life expectancy at birth
United Kingdom, Scotland, Glasgow (Calton)[b]	54
India[a]	62
United States, Washington DC (black)[c]	63
Philippines[a]	64
Lithuania[a]	65
Poland[a]	71
Mexico[a]	72
United States[a]	75
Cuba[a]	75
United Kingdom[a]	77
Japan[a]	79
Iceland[a]	79
United States, Montgomery County (white)[c]	80
United Kingdom, Scotland, Glasgow (Lenzie N.)[b]	82

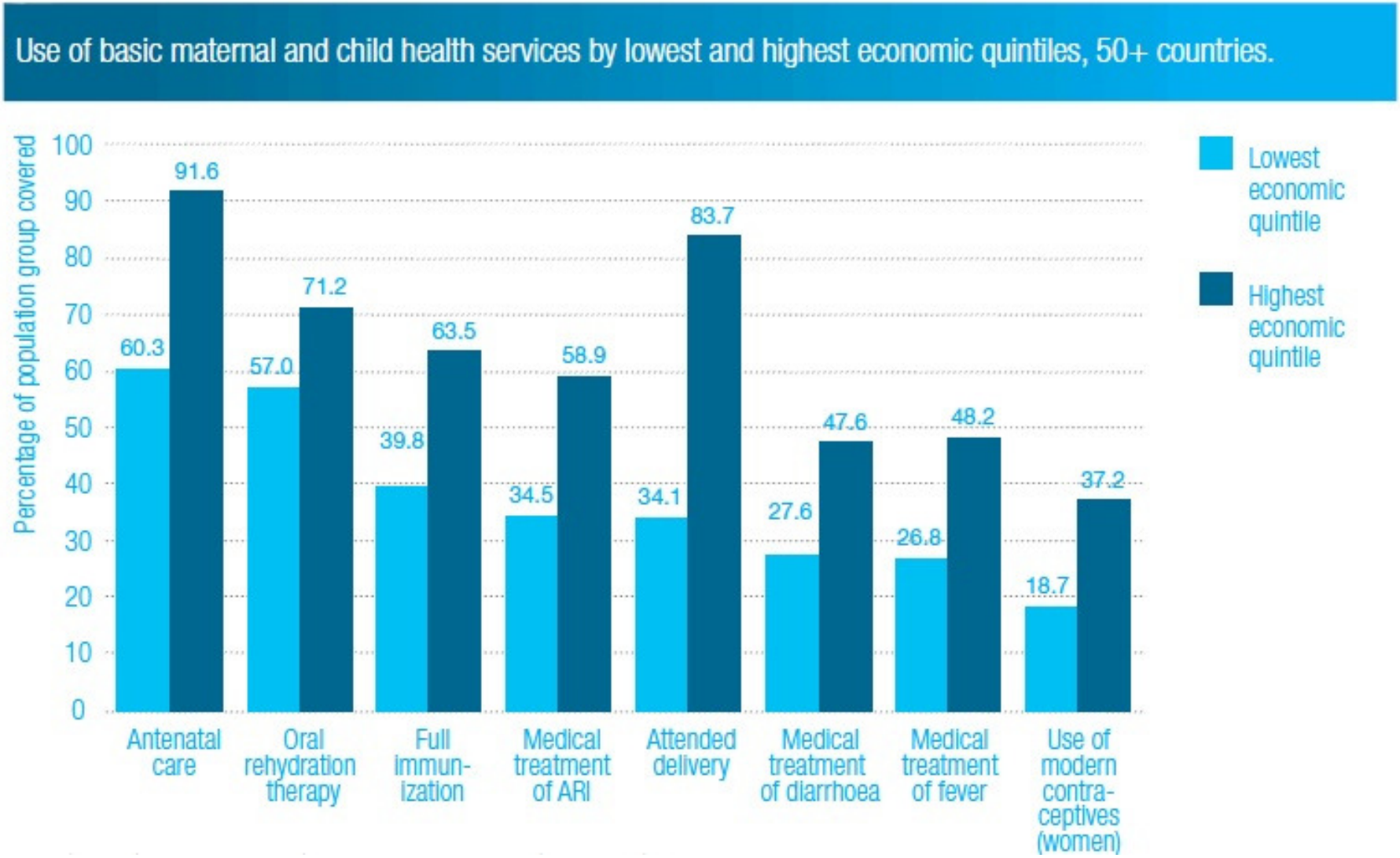
Male Life Expectancy at Birth according to the place of birth

Source: WHO Commission on Social Determinants of Health, 2008



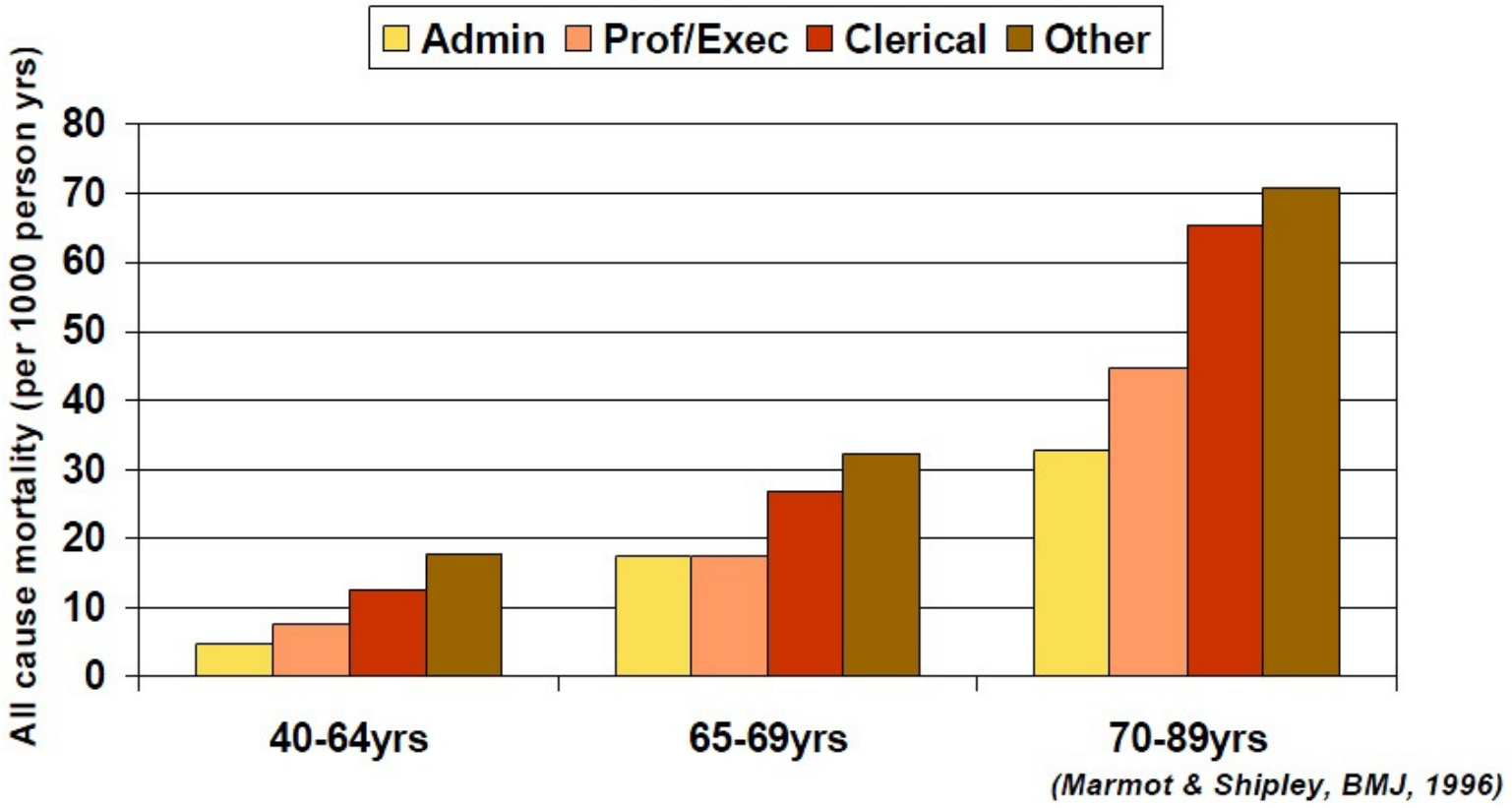
Under 5 Mortality Rate according to the levels of income in 5 countries

Source: WHO Commission on Social Determinants of Health, 2008



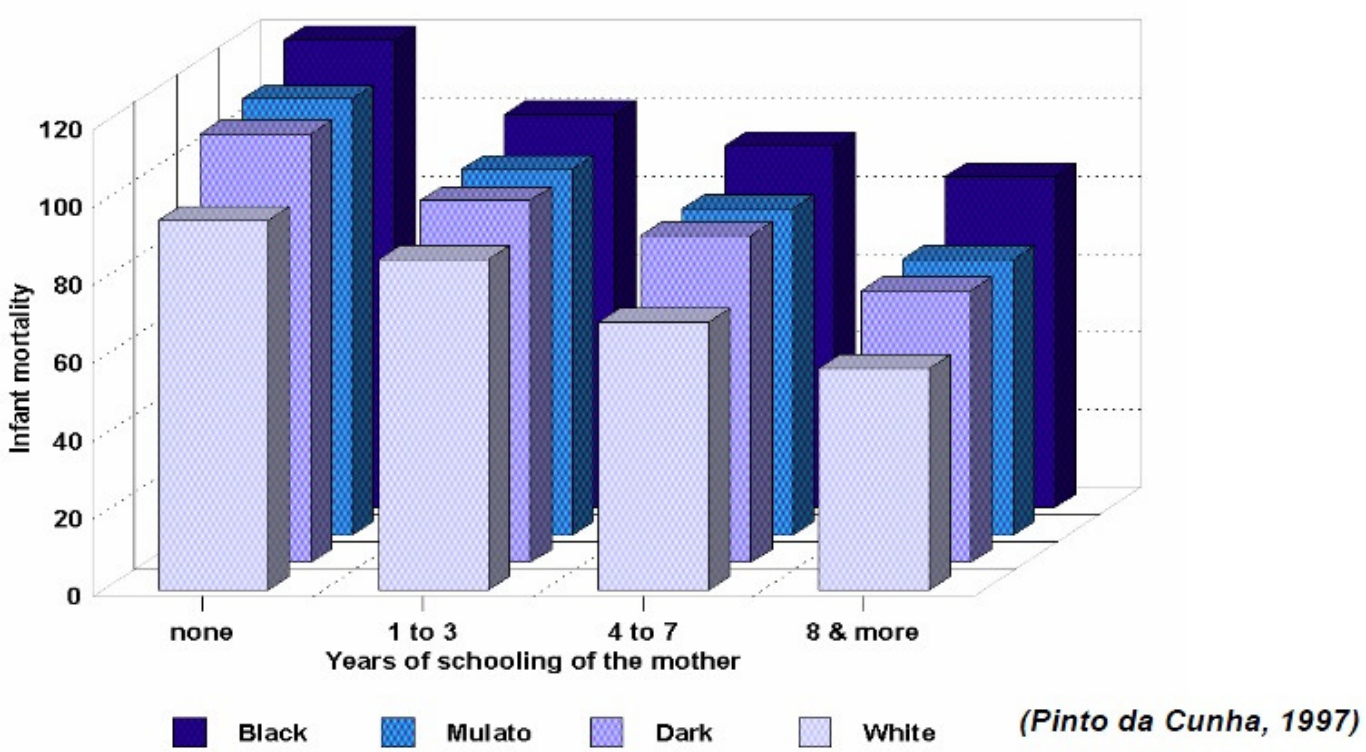
Utilization of MCH services according to the income

Source: Gwatkin, Waastaff & Yazbeck 2005



Whitehall Study showing the mortality rates of various class of workers

Source: Marmot & Shipley, 1996



Infant Mortality by race and education of mother in Brazil

Source: Pinto Da Cunha, 1997

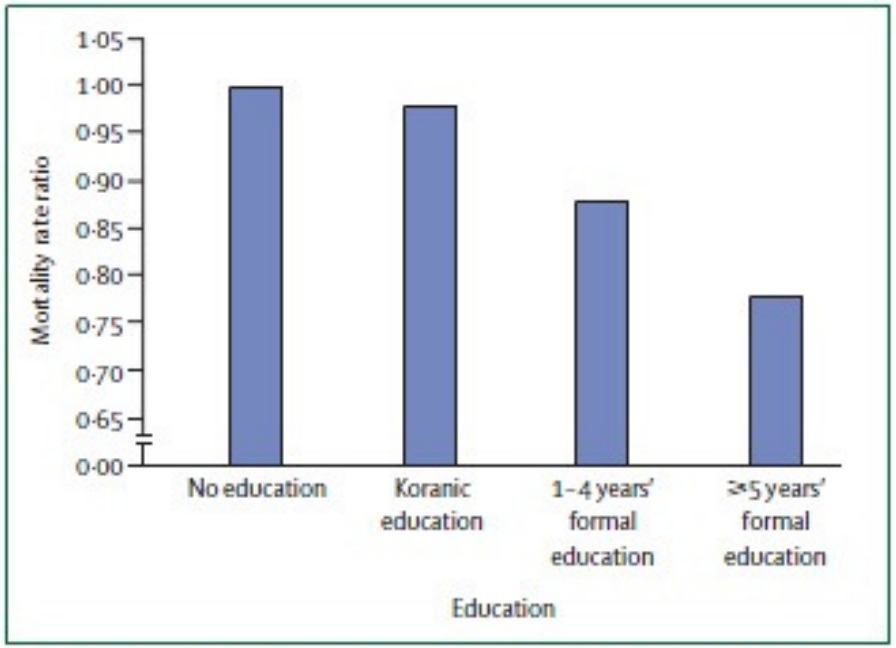


Figure 3: Mortality and education in men aged 45–90 years in Matlab, Bangladesh, 1982–98[11]

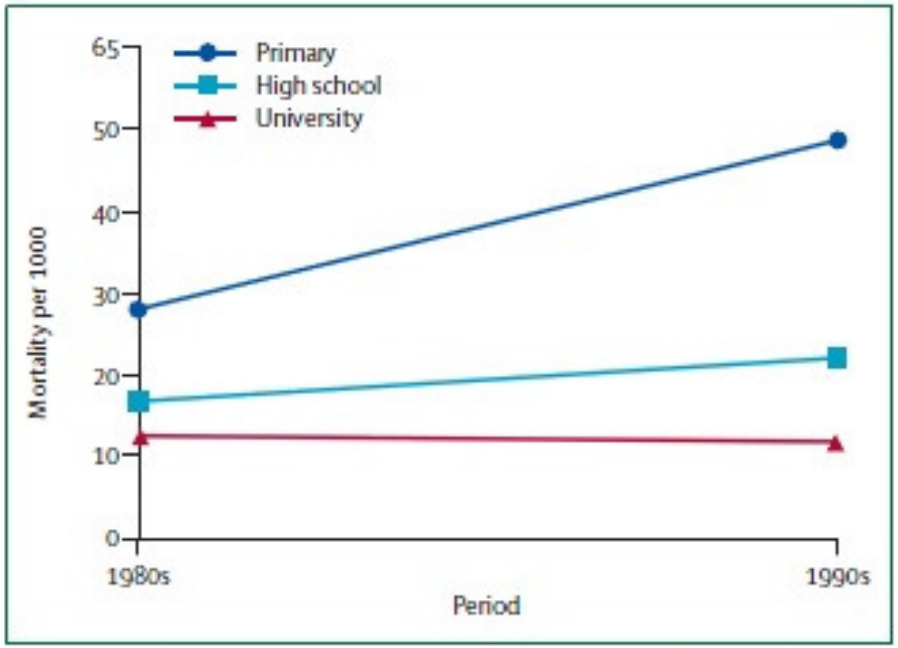


Figure 4: Increase in educational differentials in mortality between the 1980s and 1990s in St Petersburg men[16]

Mortality and Education levels

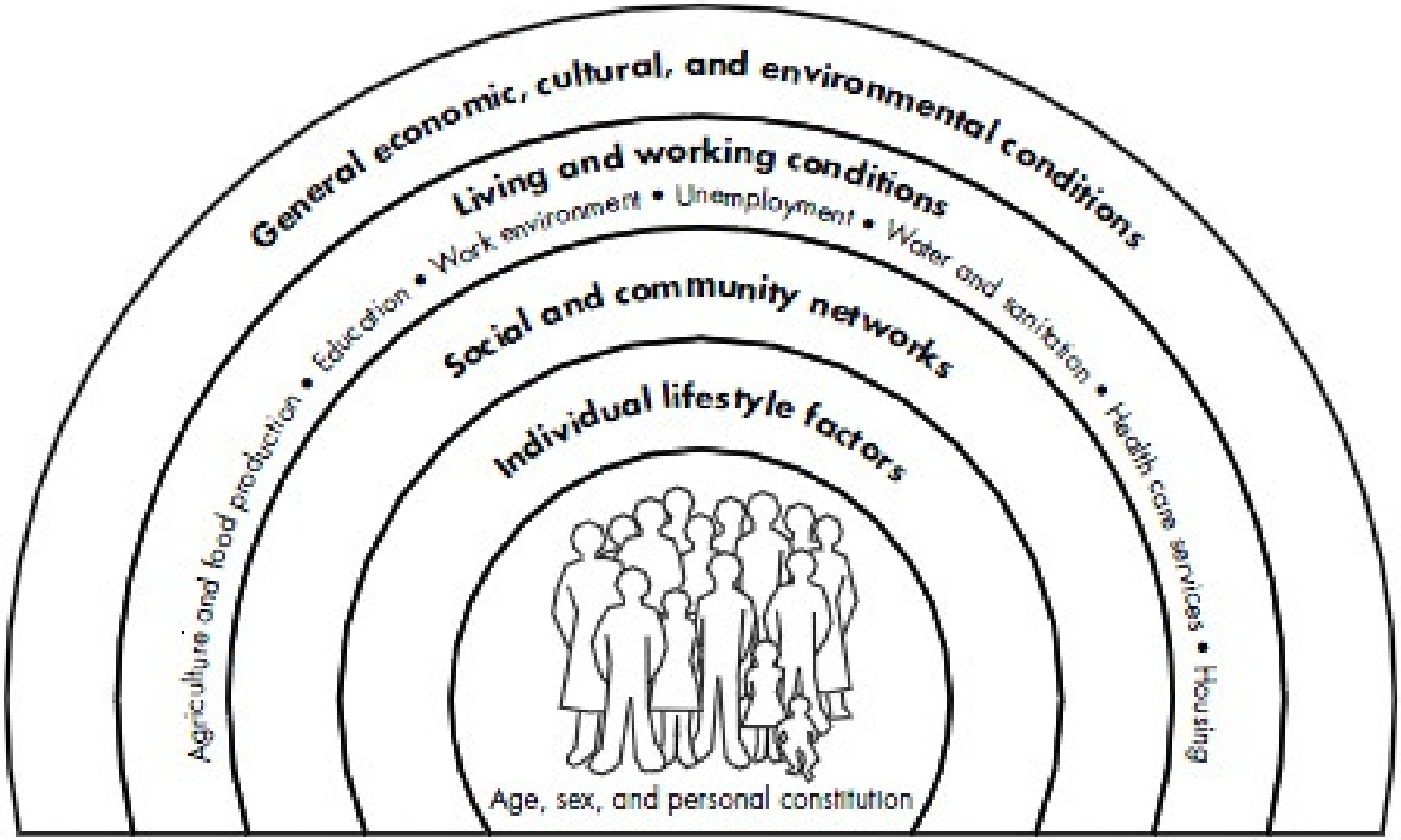
Source: Marmot, M 2005

Background characteristic	Neonatal mortality (NN)	Postneonatal mortality[1] (PNN)	Infant mortality ($_1q_0$)	Child mortality ($_4q_1$)	Under-five mortality ($_5q_0$)
Education					
No education	45.7	24.0	69.7	26.9	94.7
<5 years complete	48.4	17.6	66.0	13.8	78.8
5-7 years complete	34.5	15.1	49.5	11.5	60.5
8-9 years complete	32.0	9.5	41.5	5.6	46.9
10-11 years complete	26.9	9.6	36.5	3.6	40.0
12 or more years complete	19.6	6.3	25.9	3.9	29.7
Religion					
Hindu	40.3	18.2	58.5	18.5	76.0
Muslim	34.1	18.2	52.4	18.6	70.0
Christian	31.5	10.1	41.7	11.6	52.8
Sikh	35.9	9.7	45.6	6.8	52.1
Buddhist/Neo-Buddhist	43.0	9.8	52.8	17.1	69.0
Other	43.3	41.4	84.6	50.4	130.7
Caste/tribe					
Scheduled caste	46.3	20.1	66.4	23.2	88.1
Scheduled tribe	39.9	22.3	62.1	35.8	95.7
Other backward class	38.3	18.3	56.6	17.3	72.8
Other	34.5	14.5	48.9	10.8	59.2
Wealth index					
Lowest	48.4	22.0	70.4	32.3	100.5
Second	44.6	24.0	68.5	22.6	89.6
Middle	39.3	19.1	58.3	14.4	71.9
Fourth	31.9	12.1	44.0	7.5	51.2
Highest	22.0	7.2	29.2	4.8	33.8

IMR and Social Determinants of health

Source: NFHS3, 2006

A Conceptual Model of the Social Determinants of Health



Source: Dahlgren and Whitehead, 1991

SOCIAL DETERMINANTS OF HEALTH

The social determinants of health are conditions in which people

- are born
- grow up
- Live
- work
- age,
- Also the systems that are put in place to deal with illness.

These are in turn shaped by a larger set of structural forces: economics, social policies, and politics

Source: WHO Commission on Social Determinants of health, 2008

Politics and Political Economy of Health

- Politics – As acts of governments – very narrow definition

- *Politics as power – Politics is the process through which desired outcomes are* achieved in the production, distribution and use of scarce resources in all areas of social existence – Most commonly understood

- Politics also means autonomy over one's own health and one's own bodies

Bambra et al 2005

- Politics - to search for the common good and just society

Beauchamp, D 1976

- Rudolf Virchow's famous statement – *'medicine is a social science, and politics is nothing but medicine on a grand scale'*

- Social determinants of health are amenable to political actions – Political parties have shaped the reduction of inequalities and thereby health outcomes

Navarro 2006

MARKET LOGIC

- Entitlements to people to what they have acquired

- Emphasis on Individual responsibility – primary duty to avert death and disability is with the individual ignoring the pre-conditions for such a behaviour.

- Victim blaming and moves the debate away from the “structural violence”

- Fatalism and a weakening of the collective endeavour

- Minimal obligations to protect the common good

- Over reliance on Biomedicine - technological fix for a painful social change

- ‘Winner takes all’. Does not recognize the social / societal inequalities.

Source: Beauchamp, D 1976

JUSTICE

- Justice

- Justice as fairness and reasonableness

- Justice means each person receives his /her due

- Burdens and benefits are equally shared and distributed

- The powerful minority accepts their fair share of burden and needs to protect the powerless majority threatened with death, disease and disability

SOCIAL JUSTICE

- Under Social Justice all persons are entitled to all the ends equally such as health protection or minimum standards of income.

- Importantly burdens are collectively accepted otherwise powerful forces will obstruct fair distribution

- ***'The dream of public health is of minimizing preventable death and disability which is also the dream of Social Justice'***.

- Social Justice framework is a powerful critique of the market justice of the unjust protection of powerful from collective burden and to the extravagant faith on the efficacy of medical care

- Public health is not just about a technical activity but is to be seen as a way of doing justice, as a way of asserting the value of human life

Source: Beauchamp, D 1976

- What are the benefits worth if they have been purchased at human cost?

SOCIAL JUSTICE

- John Rawls theory of 'Justice as fairness' advocated for fair distribution of primary goods and equality of opportunity as necessary for the development of the individual

- Daniels and colleagues explained this further by mentioning that the governments must formulate policies in such a way that the following primary goods are allocated in a fair manner :

  - Investment in early childhood development
  - Nutrition programs
  - Improvements in quality of work environments
  - Reductions in income inequality
  - Political fairness

- But Amartya Sen argued that the primary goods do not have an intrinsic value in themselves to foster development of the individual.

- For eg. A disabled person's lived experience with access to all the primary goods is different than a fully abled person and hence advocated for a 'Capability theory'

- Moving from a 'resources orientation' of Rawls' theory to 'results orientation' of the Amartya Sen's capability theory

- Capabilities are enhanced through public (Government) action to create 'pre-endowments'.

Source: Braveman and Gruskin 2003

Source: Community Health Cell

Equity in Health

- Health inequities are differences in health which are unnecessary, avoidable, unfair and unjust

- Health equity is absence of avoidable, unnecessary, unfair and unjust health differences

- Absence of systematic disparities in health between social groups due to their underlying social advantage / disadvantage. Eg of social advantage is Power, resources/wealth and prestige

- Equity is not the same as Equality

- Equity is equalising of opportunities in an unequal world

- Health Equity is equalising the health outcomes of disadvantaged

- Equity is different from targeting

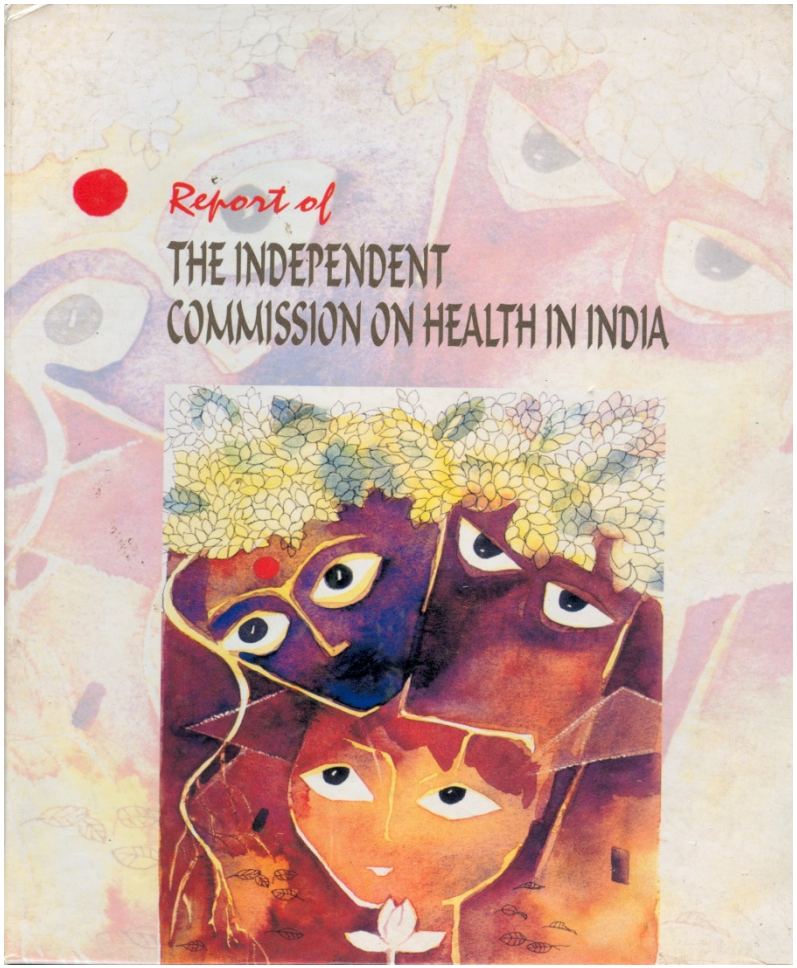
(Whitehead 1991; Braveman & Gruskin 2003)

Working on Social Determinants of Health

Is Political !!

Facilitating Health as a Social movement

1998 - Need for Countervailing Movement - An idea suggested by SOCHARA

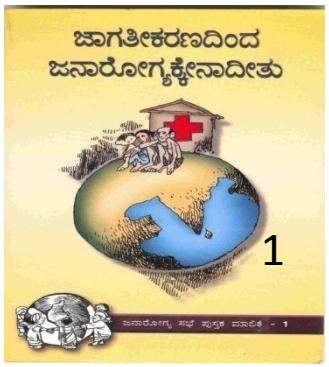


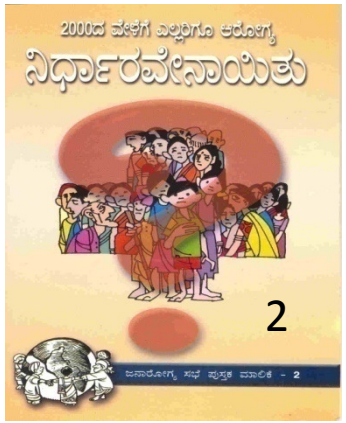
COUNTERVAILING MOVEMENT

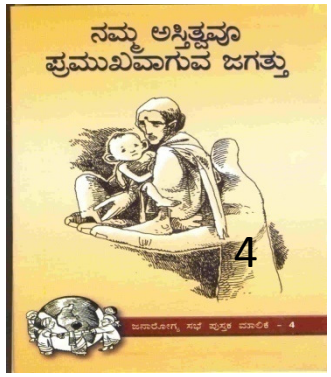
"For too long the medical profession and the medical education sector have been directed by professional control and debate. It is time to recognize the role of the community, the consumer, the patient and the people in the whole debate. …… What is needed is a strong countervailing movement initiated by health and development activist, consumer and people organizations that will bring health care and medical education and their right orientation high on the political agenda of the country. All those concerned about 'peoples needs' and 'Peoples health' will have to take on this emerging challenges as we approach the end of the millennium"

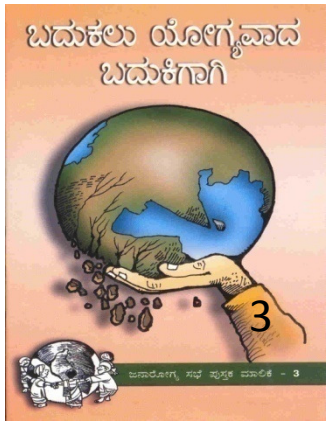
Report of the INDEPENDENT COMMISSION ON HEALTH IN INDIA, 1998 (ICHI) (Contribution from SOCHARA in the Human Resource Development Chapter).

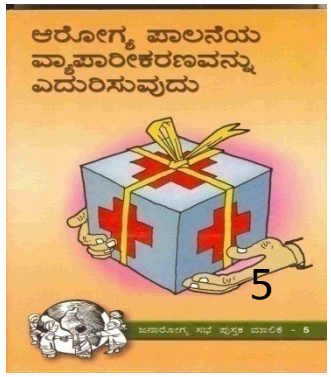
2000 AD: The People's Health Resource Books in India











1. Globalization and Health
2. Primary Health Care?
3. Inter-sectoral Action
4. Empowerment of the socially Marginalised
5. Confronting Commercialization of health care

"These books are the best expressions of primary health care concepts and its politics that I have ever read. They are the bible of primary health care, a glorious milestone on the tortuous road to primary health care…."

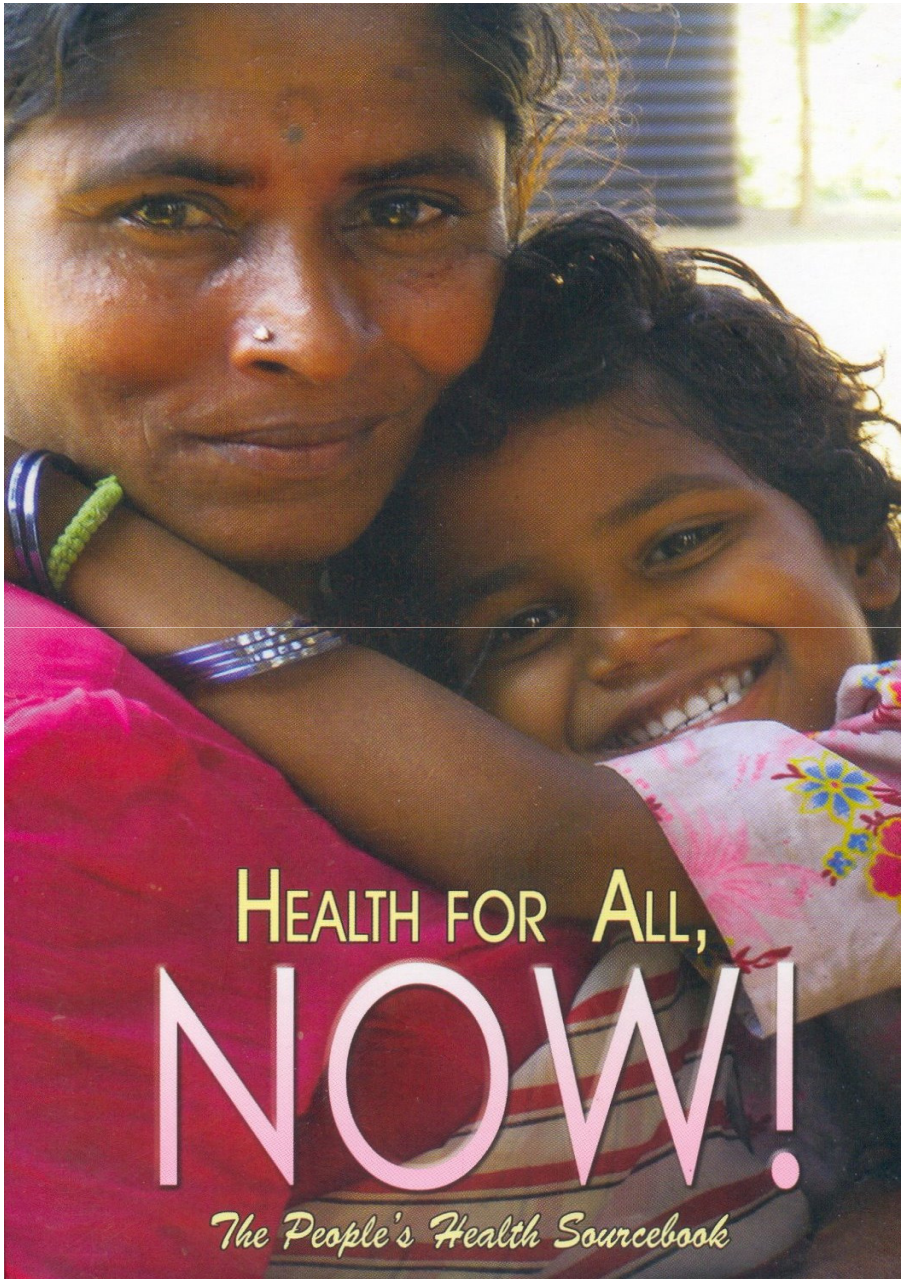
Halfdan Mahler, DG Emeritus, WHO
and Architect of the Alma Ata Declaration.

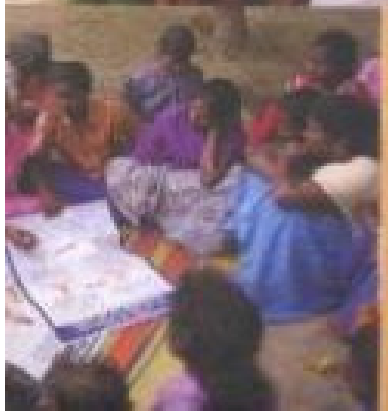
2000 - Jan Swasthya Sabha, Kolkata

- Over 2000 participants
- Mobilization across 19 states
- Adopted 20 point Indian People's Charter
- Launched the Jan Swasthya Abhiyan, campaigning for

➢ **Health for All Now**

➢ **Health as a Fundamental Human Right**

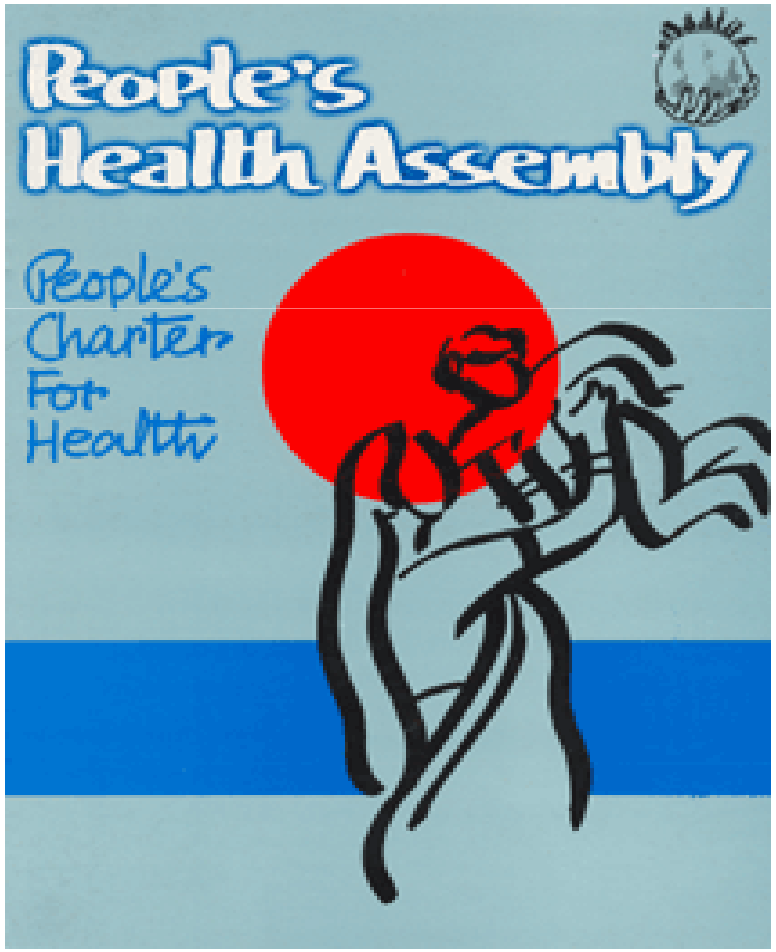

HEALTH FOR ALL,
NOW!
The People's Health Sourcebook



2000 - The First Global People's Health Assembly , Bangladesh, in December

- **In 2000 Dec, 1454 health activists from 75 countries met in Savar, Bangladesh to discuss the challenge of attaining Health for All, Now!**
- **Over 250 Indian delegates attended.**

2000:The People's Charter for Health



*"Health is a social, economic and political issue and above all a fundamental human right. **Inequality, poverty, exploitation, violence and injustice are at the root of ill health** and the deaths of poor and the marginalized people."*

2003: Right to Health Movement - India

Social Movements including Health For All Movement - gains in India till 2013

Already achieved:

- **Right to Information (RTI)**
- **Right to Employment (NREGA)**
- **Right to Education (RTE)**
- **Right to Food Security (RTF)**
- **Anti Corruption Movement (Jana Lokpal & AAP)**

Movements ongoing and or starting up

- **? Right to Health (RTH) (NRHM is a beginning)**
- **? Right to Universal Health Coverage (UHC)**
- **? Right to Women Safety**
- **? Right to Water (RTW)**
- **? Right to Mental Health (RCMH)**

ARE YOU GOING TO BE PART OF IT ???

2005: Globalizing solidarity

from over 80 countries at the Second People's Health Assembly, Cuenca Ecuador

SOCHARA hosted PHM Global Secretariat 2003- 2006

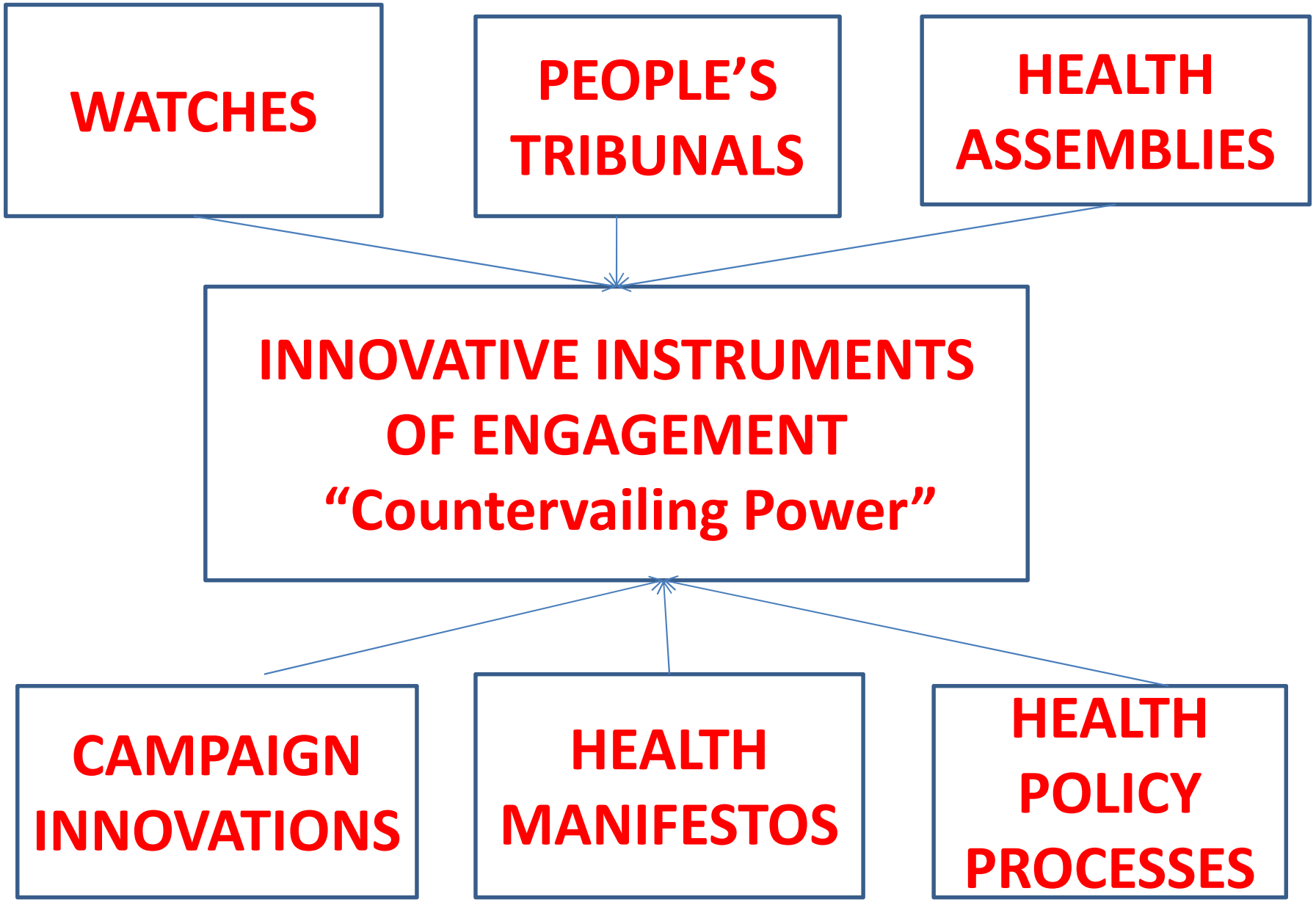
UNDERSTANDING SOCIAL MOVEMENTS

A form of collective action aimed at social reorganization……..not highly institutionalized but arising from spontaneous social protest directed at specific or widespread grievances'

Source: Dictionary of Sociology

"A spontaneous reaction to a given social, economic, or political situation and may acquire a formal or quasi – formal organization structure"

Source : Jayaram.N

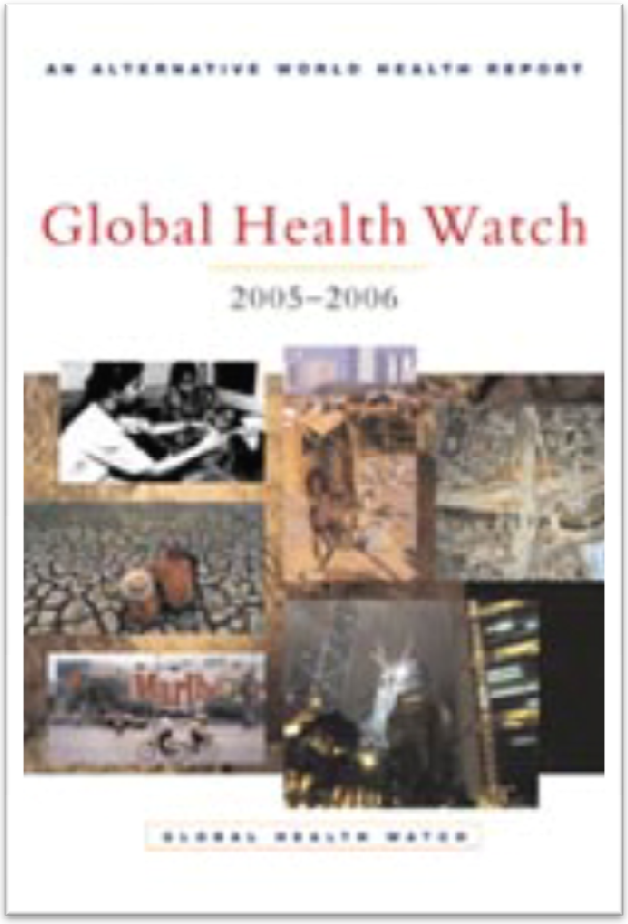

WATCHES
PEOPLE'S TRIBUNALS
HEALTH ASSEMBLIES
INNOVATIVE INSTRUMENTS OF ENGAGEMENT "Countervailing Power"
CAMPAIGN INNOVATIONS
HEALTH MANIFESTOS
HEALTH POLICY PROCESSES

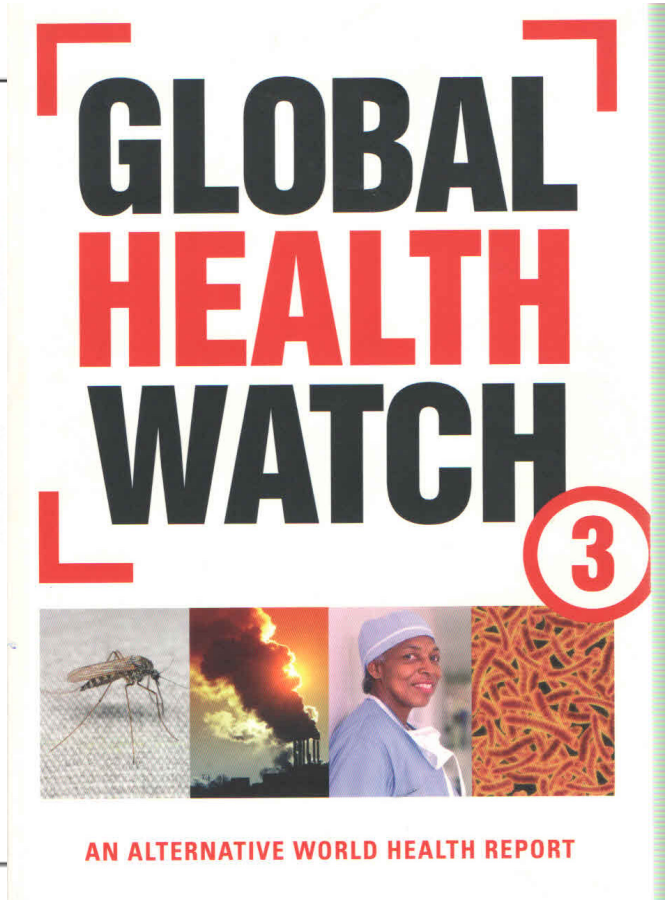
AND OTHERS ……

Innovative Instruments – 1

Global Health Watch – I II & III

Alternative World Health Report





(People's Health Movement, Medact, Global Equity Guage Alliance Health Action International, Medico International, Third World Network, Zed Books)

INNOVATIVE INSTRUMENTS- 2

People's health tribunals in India

(Jan Sunwais – Jan Samvad)

INNOVATIVE INSTRUMENTS- 3
(Health Assemblies)

Innovative instruments - 4

CAMPAIGN INNOVATIONS

Right to Primary Health Care Campaign- South India

Innovative instruments - 5

Peoples Health Manifestos India – 2004, 2009, 2014

(Dialogue with all political parties)

POLICY BRIEF

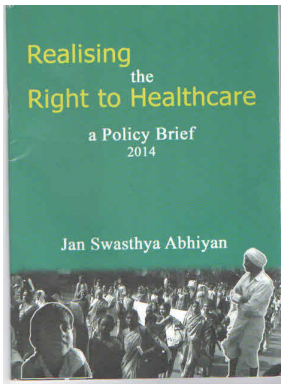
MOVING TOWARDS RIGHT TO HEALTH CARE

Why Right to Health Care ?

Health is one of the goods of life to which man has a right; wherever this concept prevails the logical sequence is to make all measures for the protection and restoration of health to all, free of charge; medicine like education is then no longer a trade - it becomes a public function of the State ... Henry Sigerist

Even after 57 years of Independence the Indian State has failed to provide its citizens the basic requirements like food security, health care, housing and education, which are the basis for reasonable human existence. Due to rampant poverty and lack of social equity large sections of population have been denied adequate nutrition, clean drinking water and sanitation, basic quality health care to all those who cannot afford it. The first National Health Policy (NHP) of 1983 made its motto 'Health Care for All by 2000' which has not happened, while the subsequent National Health Policy 2002 welcomes the participation of the private sector in all areas of health activities thus in a sense endorsing inequity. The failure of National Health Policies to introduce social justice and equity has brought to the forefront the issue of need for a comprehensive legislative framework to empower the vast impoverished masses with rights for a healthy life.

While Universal Access to Health Care will be the ultimate aim, the promulgation of a comprehensive



Suggested effective measures to achieve right to health

- **Enactment of National Health ACT- to guarantee the basic affordable quality health care services in all clinical establishments including the private establishment**
- **Rural Infrastructure and the National Rural Health Mission- Increased allocation and effective utilization of Funds and strict action on corruption**
- **Drug Medicines and Patents- List of Essential and Consumable drug s by the state. Ethical code of marketing medicine and revival of public sector companies on medicine and vaccines**
- **Gender and Health – Abolish coercive laws on policies and practices that violate the reproductive and democratic rights of women and Assure women of gender-specific health entitlements**
- **Child Health and Nutrition – Urgency for a National policy on Child health and nutrition. Universalization with quality IDCS**

INNOVATIVE INSTRUMENTS- 6

Social Networking & Media Efforts

Health for All Now!
People's Health Movement

www.phmovement.org

sochara
building community health

www.sochara.org

medico friend circle

www.mfcindia.org

communityhealth.in

www.communityhealth.in

Community Practice on Accountability and Social Action in Health -COPASAH

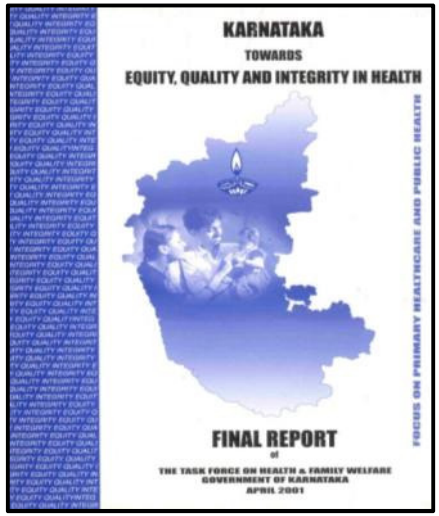
www.copasah.net

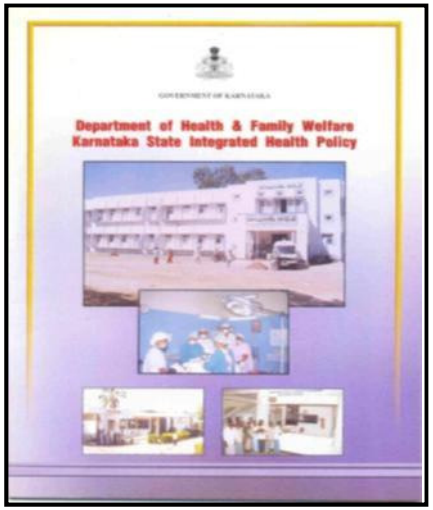
Public Health Resource Network

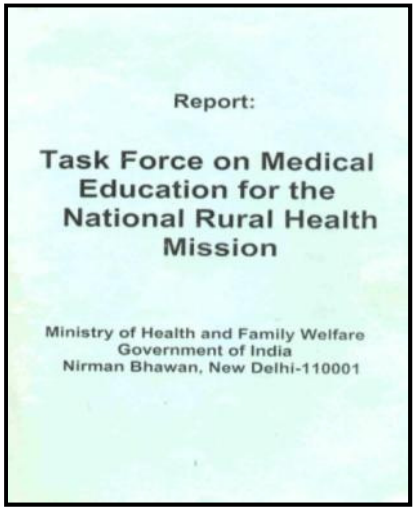
PHRN

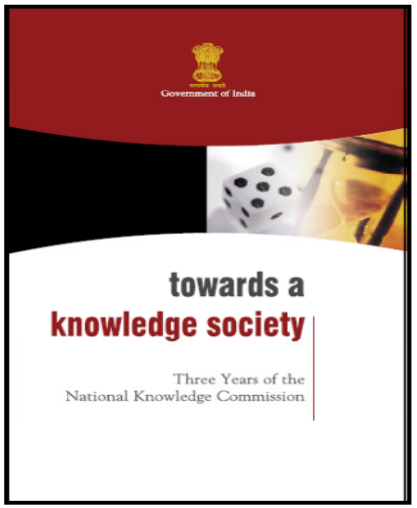
www.phrnindia.org

MAINSTREAM DEVELOPMENTS IN PUBLIC HEALTH WITH PARTNERSHIP OF ALTERNATIVE SECTOR – 1998-2008









Advocacy by PHM with WHO on Social Determinants of Health

- WHO and UNICEF were invited for the Dhaka Assembly in 2000 but both ignored

- Surprisingly World Bank, whose policies were severely critiqued, chose to send a representative for the Assembly

- 2001 - A WHO Advocacy Circle was formed by the Movement

- April 2001 – Provocative in-house workshops were held in WHO by PHM friends inside WHO

- May 2001 - DG-WHO starts a WHO Civil Society Initiative and PHM leaders invited for World Health Assembly in 2001

Advocacy by PHM with WHO on Social Determinants of Health

- Nov 2001 – Global Forum for Health Research invited PHM after noting the pro-poor orientation of the People's Health Charter

- May 2002 – WHO invited PHM to present the Charter as part of a technical briefing for the 55th WHA. 35 member strong PHM delegation makes a forceful plea for WHO to look at SDH beyond disease based vertical programs

- This dialogue receives wide coverage in Lancet and also the internal documents of WHO

- 2003- PHM also initiates a debate through Lancet on the election of new DG WHO

Advocacy by PHM with WHO on Social Determinants of Health

- May 2003 – 25th Anniversary of Alma Ata – PHM releases the Alma Ata pack. 82 PHM delegates gatecrash into WHA that year !

- May 2003- PHM was invited for a dialogue by the then DG – Late Dr. Lee Jong Wook

- July 2003 – The then Global coordinator of PHM famously critiqued the WHO Macroeconomic Commission for Health and challenged WHO to instead constitute a “Poverty and Health Commission” to look at SDH

- Jan 2004 – WHO participates in the International Health Forum in Mumbai organized by PHM represented by 4 of their permanent staff – A reversal of stance in less than 4 years

Advocacy by PHM with WHO on Social Determinants of Health

- May 2004 – 30 PHM delegates again attend WHA

- Sept 2004 – WHO decides to constitute a Commission on Social Determinants of Health (CSDH). PHM representatives invited by WHO for the preparatory meetings on CSDH

- 2005 – At the formal launch of the CSDH in Chile, the role of PHM in getting this commission constituted was acknowledged by the DG

- 2005 – PHM resource persons were also asked to be a member of the Task Force on Health Systems Research to bring in SDH

- 2005-2006 – PHM country circles facilitate the Civil Society Dialogue of the CSDH commissioners

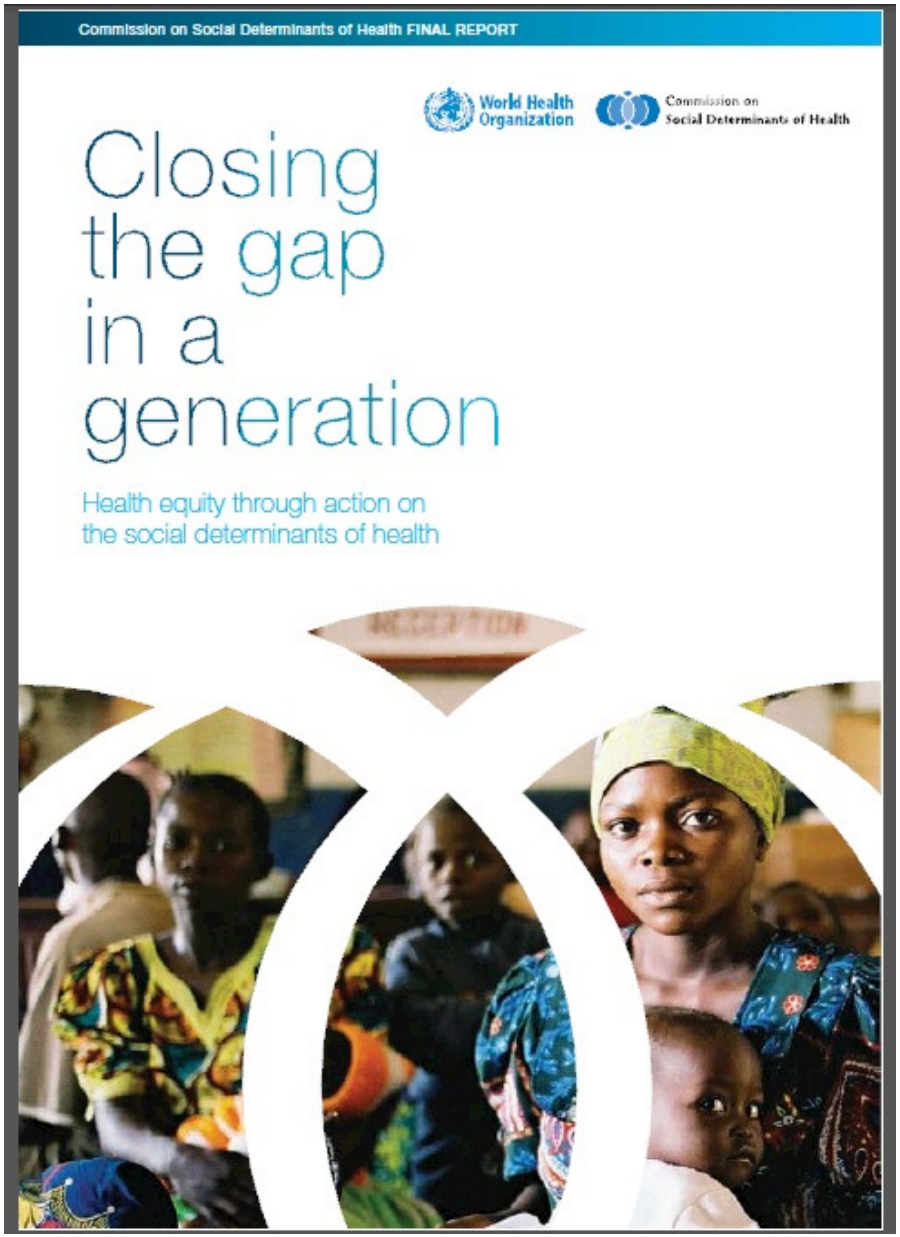
Advocacy by PHM with WHO on Social Determinants of Health

- 2006 – At the second People's Health Assembly in Cuenca, Ecuador - Dr. Lee, the DG sends a video message to the Assembly

- The chairperson of the CSDH and one commissioner actively participate in the Assembly.

- From a no-participation by WHO in Dhaka to an active participation in the Cuenca Assembly !

Source – Narayan R (2006)



WHO COMMISSION ON SOCIAL DETERMINANTS OF HEALTH

Report available at

http://www.who.int/social_determinants/thecommission/finalreport/en/

WHO COMMISSION ON SOCIAL DETERMINANTS OF HEALTH

- Convened in 2005 by the late Dr JW Lee, then DG of WHO

- Mandate to investigate and report on evidence to guide action on social determinants of health to reduce health inequities

- 20 commissioners, chair Prof. Sir Michael Marmot.

- Dr. Fran Baum, Convenor of PHM Australia, was one of the Commissioners.

- Another PHM Resource person, Dr. Ron Labonte, from University of Ottawa, Chaired the Globalization Knowledge Network of the WHO-CSDH

WHO COMMISSION ON SOCIAL DETERMINANTS OF HEALTH

Main Recommendations

- Improve Daily living conditions of people

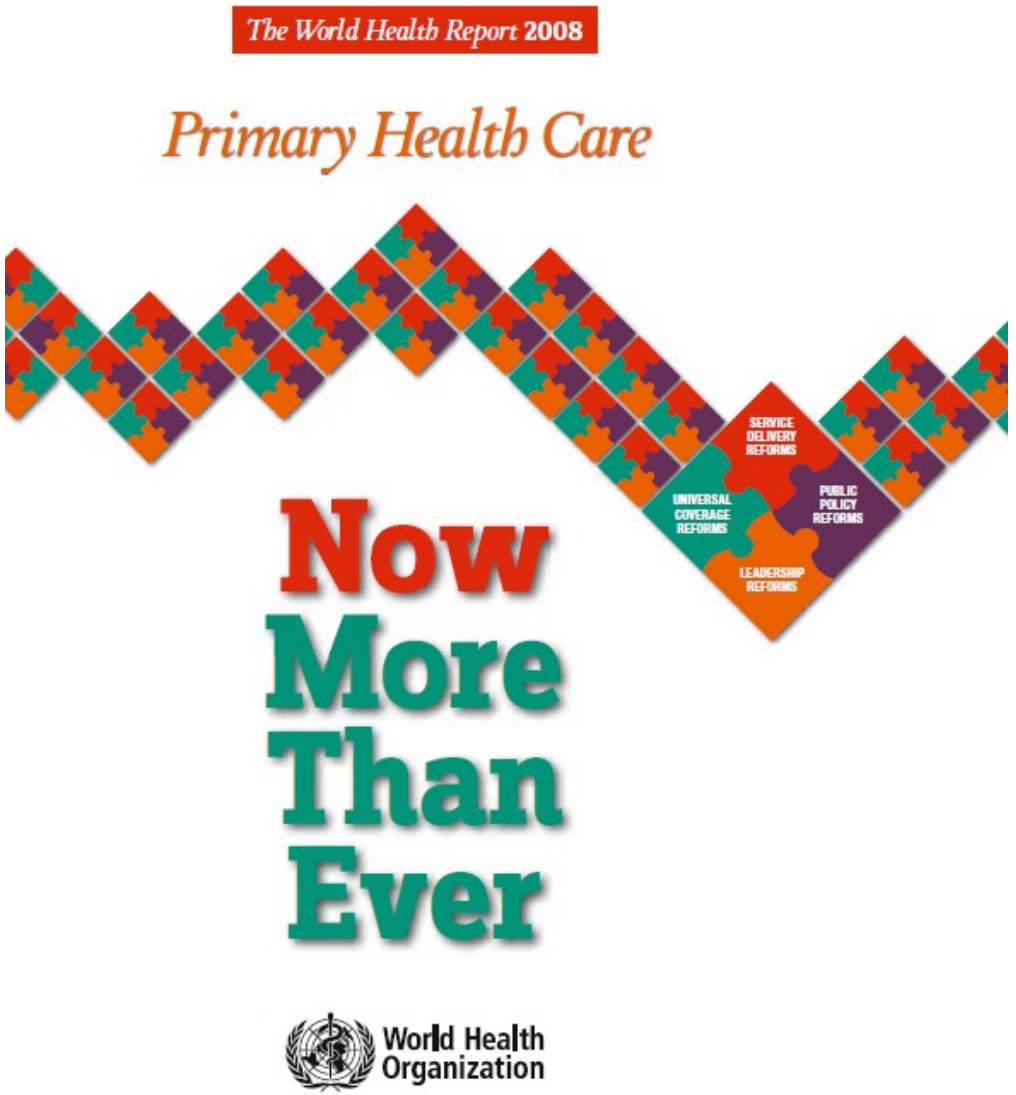
- Tackle the inequitable distribution of power, money and resources

- Measure and Understand the problem and Assess the impact of action

WHO COMMISSION ON SOCIAL DETERMINANTS OF HEALTH

- Four streams of work
  - –Knowledge networks
  - –Country partners
  - –Civil Society
  - –WHO

- Three year, collection of knowledge and evidence on health inequities and the social determinants of health



WORLD HEALTH REPORT OF 2008

Report available at http://www.who.int/whr/2008/en/

Global Campaign against Indian Patents Amendment (GCAIPA)

The Movement gave a "Global Call" against the Patents Amendment brought out by the Indian Government for Feb 26, 2005.

Response to the Global call at the Global Level:

The International Humanitarian Organisation **Médecins Sans Frontières (Doctors without Borders)** out a letter to the President of India, the Prime Minister of India and Ms. Sonia Gandhi opposing the Amendments. They had also released it to the Indian Media

Geneva: NGO Forum for Health sends a letter to the Indian Government through the Ambassador of India at the UN opposing the Amendments

•Germany:

BUKO Pharma Campaign sent out protest letters to the various ministers and the Indian Embassy in Germany.

German network against AIDS (where all major NGOs in Germany are part of) sent a fax to the Indian Embassy in Germany

Morocco: The Coalition for the Right to Care and Access to Medication in Marrakech, Morocco, issued a press release condemning the Amendments and also sent an open letter from an HIV/AIDS patient to the Indian Ambassador to Morocco

Burkina Faso: There was a rally taken out in Ouagadougou, Burkina Faso by people with AIDS who use Triomune a lot and some of the slogans were "Génériques toujours !" = "generics forever !" "Inde : sauveur hier, criminel aujourd'hui" = "India : saviour yesterday, criminal today"

United States of America: The Association for India's Development, Insaaf, Global AIDS Alliance and such other organizations organized a rally in front of the Indian Embassy in Washington. Some of the individual chapters of these organizations also sent out press notes to the Indian media

France: Act-up Paris, ATTAC and Solidarite Sida organized a protest Rally in front of the Indian Embassy in Paris.

South Africa: Treatment Action Campaign in South Africa picketed against the Patents Amendment and submitted a memorandum addressed to the President and Prime Minister of India.

South Korea: A group in Korea, People's Health coalition for equitable society and Human Right Advocacy Group NANURI+ in response to the Global Call submitted a memorandum to the Indian Ambassador

WHO: WHO writes a letter to the Health Minister urging him to make use of TRIPS flexibilities

UNAIDS: UNAIDS writes a letter to the Commerce Minister urging him to make use of TRIPS flexibilities

Build-up to the Campaign

21 Jan 2005 – Patents convention held in **Chennai**

9 Feb 2005 – A workshop for the Trade Unions in **Mumbai**

12 Feb 2005 – A city meeting on Patents held in **Hyderabad**

13 Feb 2005 – Patents issue discussed at a meeting of the Western regional NGO's held in **Mumbai**

15 Feb 2005 – A workshop held in **Kolkata**

19 Feb 2005 - Patents Convention was held in **Pune**

20 Feb 2005 – A Patents Convention was held by FMRAI in **Mumbai**

20 Feb 2005 – A television debate on patents issue participated by Prasanna

21 Feb 2005 – A workshop with the Health Care workers held in **Bangalore** and as a follow up a workshop was held separately at St. John's Medical College and NIMHANS

21 Feb 2005 – Dharwad: Dr. Gopal Dabade and others from Drug Action Forum Karnataka met the 2 Members of Parliament

25 Feb 2005 – A Protest Convention was held in **Pune** one day before the Global Call

On 26 Feb 2005 – Rallies, picketing, memorandums were submitted in all major cities of India like New Delhi, Mumbai, Bangalore, Kolkata, Kerala, Hyderabad, Chennai, Goa, Pune, Dharwar and even Washington in the US

Outcome of the Global Call

We had a 'bad' bill from a 'Disastrous' bill

Pre-Grant Opposition was restored

Rejects Patents for new forms of earlier medications

Tightened Compulsory Licensing provisions a little but still left the questions of time and royalty open to endless negotiations

Allowed for the continued manufacture of drugs in the market after 1995

Allowed for the export of medicines to the LDCs without any Compulsory Licensing provisions in those countries

For further information visit

www.sochara.org

www.phmovement.org

www.ghwatch.org

www.phmovement.org/iphu

www.mfcindia.org

www.communityhealth.in

http://www.phmovement.org/iphu/

http://mohfw.nic.in/NRHM.htm

THANK YOU