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# TOWARDS FULFILLMENT OF 'INCLUSIVE HEALTH FOR ALL (SDG 3)': ANALYZING DIMENSIONS OF HEALTH AND ILLNESS THROUGH SOCIOLOGICAL LENSES "

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## *Abstract*

The subject matter of health and illness has largely been considered relevant to the medical domain. But dwelling into the social determinants of health and illness, sociologists have highlighted the social causative factors impacting one's health status respectively. The Marxian idea of worker's exploitation and consequent poor health, Foucaultian idea of madness, etc and other examples have been cited in this paper to highlight the social determinants of health and illness. The paper also tries to shed light on how sociological determinants of health could be taken care of in a holistic manner for achieving "health for all", in convergence with the Sustainable development goal 3 for 2030. Further, the paper finds lack of adequate qualitative data in this area especially in the case of Indian society, and thus presses for promotion of more mixed method oriented research having participation of sociologists, healthcare professionals and policy makers along with people who are at the receiver end. In the concluding remarks the paper highlights the need of tailored policy initiatives to suit the health related needs of all sections of society and eventually make good health sociologically inclusive and equitably accessible to all.

***Index Terms***- Climate and health, Health inequality, Illness, Mental health, Mortality, Social stratification, Social determinants, Sustainable Development Goals, World Health Organization

## *INTRODUCTION*

The Oxford dictionary of sociology by John Scott describes ill health as a bodily or mental state which is deemed undesirable. Consequently, interventions to ameliorate such state should be justified. This position was analyzed in a greater depth by Talcott Parson in his description of 'sick role'. The field of health and illness in sociology is concerned with broadly three areas- conceptualization of health and illness in sociological terms, study of their measurements and social distribution, and then further providing explanations to the recurring patterns of health and illness .

Engels , one of the most ancient thinkers in the field of social science , was among the initial researchers to highlight the relation between health and its social determinants. Citing case study and statistical methods he argued that one of the major cause of premature mortality in England was due to class exploitation

### *Joining the dots between health, illness and sociology*

Michel Foucault provided the description of how a behavior which is perceived as normal , begins to be looked at as a pathological problem , as a disease when society tries to control it. Citing example of mad people in his book "*Madness and civilization (1961)"* Foucault describes that , prior to the 18$^{th}$ century Mad was free form state's interference. But with the development of psychiatry as a discourse , society began to exert control

over a certain section of people among the whole population . This is an example of deviant behavior which is relative and depends on the larger context of society.

In the 19th century western world, men used to upheld patriarchal norms of society and tried to confine women within the four wall. It was said that men and women have different biological specialties. Men have brain dominant while women have ovaries and uterus dominant. Also it was argued that if women enter the workforce , then their brains will develop and this will lead to underdevelopment of their reproductive systems. This hysteric belief was propagated in society to prevent women from joining the new emerging occupations like school teaching, nursing and voluntary reforms respectively. Women's health and illness was cited to keep the abusive patriarchal norms of society prevalent.(White, 2002)

Table 2 *Types of asset flow salient for health and longevity*

**Biological** (or 'body') assets can be affected by class relations even prior to birth. Low-income families, for example, are more likely to produce babies of low birthweight; and low birthweight babies carry an increased risk of chronic disease in childhood, possibly through biological programming.

**Psychological** assets yield a generalised capacity to cope, extending to what is increasingly conceptualised as 'resilience'. In many ways the 'vulnerability factors' that Brown and Harris (1978) found reduced working-class women's capacity to cope with 'life events' of causal importance for clinical depression are class-induced interruptions to the flow of psychological assets.

**Social** assets have come to assume pride of place in many accounts of health inequalities, and feature strongly in the contributions of Marmot and Wilkinson. Social assets, or 'social capital', refer to aspects of social integration, networks and support. The political manipulation of social capital should not lead to its neglect.

**Cultural** assets, or 'cultural capital', are generated initially through processes of primary socialisation, subsequently encompassing formal educational opportunities and attainment. Class-related early arrests to the flow of cultural assets can have long-term ramifications for job prospects, income levels, and therefore health.

**Spatial** assets have been revealed as salient for health via area-based studies. These studies have shown that areas of high mortality tend to be areas with high net out-migration; and it tends to be the better qualified and affluent who exercise the option to move.

**Symbolic** assets represent the variable distribution of social status or 'honour'. Status/honour is known to impact on people's health. It has been shown for example to exercise an impact via people's sense of 'where they stand' relative to others comprising their reference groups.

**Material** assets translate into 'standard of living'. Relative poverty or deprivation due to impoverishment and meagre standard of living has long been associated with diminished health and reduced longevity, although the mechanisms linking material disadvantage with health remain hotly debated.

Source: Adapted from Scambler and Scambler (forthcoming).

| Theory | Model of Society | Cause of Disease | Role of the Medical Profession |
|---|---|---|---|
| Marxist | Conflictual and exploitative | Putting profit ahead of health | To discipline and control the working class; and provide individualized explanations of disease |
| Parsonian | Basically harmonious and stable set of interlinked social roles and structures | Social strain caused by meeting the demands of social roles | Rehabilitate individuals to carry out their social roles |
| Foucauldian | A net of power relations, with no one dominant source – administered surveillance | 'Diseases' are labels used to sort and segregate the population to make it easier to control | To enforce compliance with 'normal' social roles; and to ensure that we internalize these norms |
| Feminist | Exploitative and repressive of women through patriarchy | Carrying out the social role enforced on women by patriarchal men; the medicalization of a woman around her reproductive life cycle | To enforce conformity with patriarchal norms of femininity and motherhood |

Source ; Introduction to sociology of health and illness, Kevin white.
Source: Sociology of health and illness, G Scambler.

Link and Phelan (1995) in their study conclude that health has social causes which are fundamental. The people who have lesser social value are more prone to suffer from poor health conditions

Table 1 *Valued versus devalued social statuses*

| *Social status* | *Valued* | *Devalued* |
|---|---|---|
| Gender | Male | Female |
| Race | White | Non-white |
| Language | English | Other |
| Religion | Christian | Muslim |
| Sexuality | Heterosexual | Homosexual |
| Life cycle | Adult | Child/Senior citizen |
| Education | Educated | Illiterate |
| Physical health | Healthy | Unhealthy |
| Ability | Able-bodied | Disabled |
| Mode of income | Work | State benefits |
| Housing | Home owner | Tenant |
| Marital status | Married | Unmarried |
| Family size | Two children | Childless/4 + children |

*Source*: From Pease (2010).

Source : Sociology of health and illness, G Scambler.

A landmark study "*Inequalities in health: the black report"* in 1982 by Peter Townsend and N. Davidson concluded that in Britain , death rates of those aged 15-60 were found to be some two and a half times as high for a person in social class 5 than in class 1. (White, 2002).

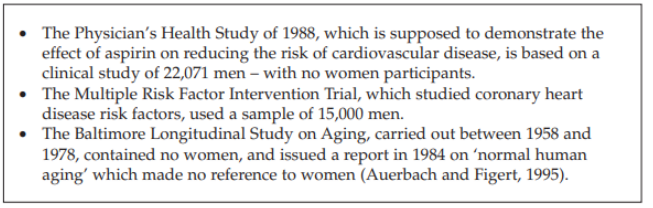
A specific sub domain in sociology of health, called as 'social constructionism', argues that medical knowledge has social explanatory terms, which are product of those specific societies which are under study.(White, 2002)

In his book *"Asylum(1961)",* Erving Goffman provided a strong critique of the discipline of medicine. He describes medicine as a value loaded system of social control, which operates under the guise of science.

According to the Demographic transition theory given by American demographer Warren Thompson, as society proceeds through different stages, the mortality rates and birth rates also vary significantly. The

industrial societies have higher average life expectancy and lower mortality rates in comparison to the preindustrial societies. This is a well established fact as well. Coming over to the age and sex related dimensions of ill health and mortality , women are usually found to have longer life expectancy than men in most societies. The aged population and the infants are more vulnerable to sickness and mortality. Similarly class based differences in mortality have also been found.(Sangwan *et al*,2019)

One of the biggest point to consider when it comes to health and illness is the quality of data being used to make decisions. Clinical trials are conducted to determine the efficiency of various medications, the health conditions of the people and their usability. But this seemingly objective experimentation too is often hidden behind the inequalities spread in society. A good point has been made by Kevin highlighting how some of the most landmark clinical trials were conducted without taking into consideration even single women participation. The findings of trials are likely to be skewed and their reliability is a question to be considered.



- The Physician's Health Study of 1988, which is supposed to demonstrate the effect of aspirin on reducing the risk of cardiovascular disease, is based on a clinical study of 22,071 men – with no women participants.
- The Multiple Risk Factor Intervention Trial, which studied coronary heart disease risk factors, used a sample of 15,000 men.
- The Baltimore Longitudinal Study on Aging, carried out between 1958 and 1978, contained no women, and issued a report in 1984 on 'normal human aging' which made no reference to women (Auerbach and Figert, 1995).

Source: Introduction to sociology of health and illness, Kevin white

Similar biasedness is also witnessed in case of racial segregations. Racial groups belonging to third world countries are often misrepresented in

clinical trials conducted by western world yet the latter claim to have universal validity of their clinical findings(Scambler, 2012).

A sociological model of disease

One sociologist who has developed such a model of disease, focusing on social causes rather than disease processes, is Peter Davis, professor of public health at Christchurch University in New Zealand (Davis, 1994). Davis' argument is that rather than focusing on individual diseases and individual bodies, health research and health policy should be directed to the economic, political and cultural institutions that produce disease. Thus he proposes classifications of disease based on the economic, social, cultural and political determinants of ill health and disease.

- In the economic sphere, the institution of the labour market, inside an economic framework of capitalism, which results in profit being placed before safety, would be shown to be the cause of industrial death and accident.
- The social shaping of disease, through the institutions of family and kinship, working themselves out in the context of urbanization and social mobility, would be targeted as contributory or causative in hypertension and mental illness.
- Cultural factors of beliefs, practices and lifestyles, usually manifest in different consumption patterns, especially of diet and alcohol, would be seen as key factors in obesity, bowel cancer and lung cancer.
- At the political level are those diseases which are a product of the structures of power and the different participation rates of different groups in an unequal society, which result in diseases due to problems of access to services and equity in the distribution of services.

Source: Introduction to sociology of health and illness,kevin white

Epidemiological studies have provided evidential support to the idea that autonomy and control at work are important factors in aetiology of heart diseases. Work which is over demanding without any compensation for the same, low job security and lack of future career prospect , is considered a s significant contributor to the same. Further, some studies have also shown the importance of pension rights when it comes to explaining differences in mortality rates among adults and retired men and women from different class backgrounds.

***Social inequality in dietary patterns and access to quality healthcare services***

Goran Therborn in his "*The killing fields of inequality,2015"* says that " *Inequalities are produced and sustained socially by systemic arrangements, processes and distributive actions, individual as well as collective. Social consequence of inequality is a violation of human dignity, denial of the possibility for everybody's human capabilities to develop" .(Sangwan et al, 2019)*

Social stratification has been one of the most important bases of health among various sections of the populations. People belonging to the lower levels of social hierarchy are often the ones who face exclusion from health services. The Indian government has time and again highlighted the high out-of-pocket expenditure on health and lack of access to quality healthcare services. The situation is worse in case of tribal communities, people belonging to lower castes, etc.

It is a universal fact that health is directly related to the food consumption pattern of an individual. The marginalized communities and the poor people usually lack access to healthy food plates. The prevalence of malnutrition, anemia , stunted growth among the deprived sections of the community is largely a sociological reality. National family health survey highlights the prevalence of anemia , malnutrition and high mortality rates among the marginal communities. Denial of access to healthy nutritious food, access to quality healthcare services are the worst forms of social inequality and are a huge hindrance in achievement of the SDG targets in the coming times.

Ageing has another social bearing in society and this is becoming a major concern especially in countries which are witnessing a decline in the young populations like Japan, China and even Indian states like Kerala, etc Due to presence of high dependency ratio in these areas, the aged people are being left on their own and are getting treatment of being socially undesirable.

***Power structure, economic deprivation and persisting health inequality***

The distribution of power structure in society also determines the allocation of resources in the society. Thinkers belonging to the Marxist school of thought have argued that the bourgeoisie class has been usurping all power and Gramsci has highlighted the hegemony of the have nots . This can be replicated in the health related area as well . Concentration of world class healthcare facilities in metro regions like Delhi, Mumbai, Bangalore on one side and lack of even maternal care facilities in the primary healthcare centers in rural areas on the other hand is a grave reality. While the number of cancer and tuberculosis patients has been increasing in India, the brunt of poor health is faced by the poor people in a multi multi-dimensional way. Daily wage labourers lose their economic opportunity, lose their health and fall into debt trap to overcome such chronic diseases. Ultimately they end up falling into vicious cycles of poverty and the cycle becomes intergenerational.

***Mental health and loneliness***

Emile Durkheim in his Le Suicide,1897 described suicide as a social fact and through the use of multivariate analysis , he concluded that two major determining factors which impacted suicide rate in any society were mainly sociological in their orientation. The degree of integration with society and the level of regulation or control exercised by society over individuals are the causative factors. (sangwan et al,2019)

This reason provided by Durkheim can be cited in the case of high prevalence of suicide among the students living in Kota and preparing for exams like JEE. High degree of isolation along with high expectations from family and other people belonging to their primary social group makes such students vulnerable to poor mental health conditions. Social stigma attached with mental health leads to resistance on their part to seek help, eventually making them commit suicide for such an apparently small reason.

Interaction with friends and family boosts our immune system and reduces our risk of diseases such as heart disease, stroke and type 2 diabetes (Shen et al., 2025). A joint research conducted by the University of Cambridge, UK, and Fudan university(China) is a good case study supplementing our points. The sample included 42, 000 adults aged between 40- 69 years. Their research was focused on analyzing which protein was in excess among the loneliness facing people and what was the correlation between these proteins and poor health of the people. They used statistical techniques like Mendelian randomization to establish the causal

relationship in their quantitative research and thus this recent study brings to limelight how social integrity is crucial for one's good health.

Professor Sahakian , dep't of psychiatry, university of Cambridge says, " *more and more people of all ages are reporting feeling lonely . That's why WHO has described social isolation and loneliness as a 'global public health concern. We need to find ways to tackle this growing problem and keep people connected to help them stay healthy".*

Scambler also emphasized on the relation between bodily response and stressful situations for a prolonged period which has been stated time and again by various literatures as well. (Scambler, 2012)

"*prolonged stress due to psychosocial factors results in an increase in 'allostatic load': if too many negative changes occur too rapidly, bodily adjustment is compromised, resulting in overload and exhaustion".*

***Skewed spread of diseases among various social communities: case studies***

White mentions the social production of cancer in western society(White, 2002). He describes how the prevalent social inequalities are manifested in the disease pattern and related mortality among the people .Environmental pollution is amongst the prime causes of cancer. But there exists a strong positive correlation between occurrence of cancer and the socio-economic condition of the patients respectively. White mentions following studies :

- Study conducted by Galway, Mayo and Roscomon in the Western Health board of Ireland, found out that between 1980s and 1990s,

there was an increase in the number of cancer patients, but there was significant increase among the semi-skilled farm workers. Farmers who had access to protective clothing and were less likely to get exposed to tractor-based crop spraying techniques were found to have lower incidence of cancer and were also less likely to develop cancer .

- The survival rate is positively correlated to the socioeconomic status of the patient. The better the socio-economic status, the higher is the survival rate of the patient. (Schrijvers and Mackenbach, 1994)
- exposure to industrial pollutants during the uterus and infant life is more among the poor people who can't escape the harmful environments, as poison passes through the placenta and breast milk. E.g. survival of nuclear radiation pollutants.

Wilkinson (1996) study provides greater insights to highlight the correlation between health and sociology. He argues that presence of income inequality leads to fragmentation and dislocation of the individual socially. This further disrupts mutuality, trust and deteriorates the quality of social relationships and eventually the health and well being of the individual gets jeopardized (Scambler, 2012).

***Climatic factors related to health and ingrained social inequalities***

In his work, Graham Scambler raised the morphological pattern of how social becomes biological by citing work of Bartley and Blane and their study conducted in 2009 on' inverse housing law'. The study showed

positive correlation between living in a poor-quality house in a severe climate region and its impact on body- *reduced lung function (Blane et al. 2000) and elevated diastolic and systolic blood pressure (Mitchell et al. 2002)*. Along with this, the study is crucial to understand the impact of poor living on the aged population. Aged people get more negatively impacted because of lack of means to renovate their homes and the other cause –their age related decline in respiratory and cardiovascular strength to cope up with extreme situations bodily. The below mentioned contribution provided by Bartley and Blane is worth.-

*"The past is written into the body while the present shapes behavior and reactions to life"*

Climate change is posing a severe threat to the food security and health of the people all over the globe. Extreme weather events like floods , drought, etc lead to large scale displacement for the people. Tribal, rural underdeveloped areas are the ones which get most affected by it and thus these regions witness high mortality rates. Emergence of new diseases like COVID -19 brought into limelight the unequal distribution of resources. Developed countries like the US were able to provide their citizens access to vaccines, paid leaves. But poor countries like the African countries faced severe constraints in accessing vaccines.

***Transnational perspective on health inequality***

Various socio-epidemiological researches indicate association of neo-liberalism with greater income inequalities, both inter as well as internationally. Countries which are inclined less towards neo-liberalism

and more towards social welfarism like Finland, Sweden and Norway have better health outcomes than those which are more neo-liberal like the Us and Britain respectively.(Scambler, 2012)

The conditions of war and conflict among nations are another case to highlight the covert nature of social inequalities existing in society. As has been highlighted by UNICEF time and again, large scale displacement of people, injuries sustained by infants and children , famine ,etc becomes the reality of the poor people in these regions .These people become more prone to poor health including all of its aspects that is physical health, emotional health and mental health.

Another significant manifestation of health inequality is witnessed by the migrant community. Migrants upon reaching new places are denied opportunities to have even the basic human necessities. Rohingya Muslims were made to live in pathetic conditions and made to survive on very little food. This is prevalent despite international laws echoing the importance of human rights and dignity.

***International calls for healthy lives for all***

Studies by Who have highlighted time and again that the health of the population depends on the collective actions to control unemployment and quality of employment , matters of social cohesion , and political factors such as tight control over food.

The health related behavior of an individual is shaped by his/her social position which is not free will. For example studies have shown that

people who are not employed are more likely to get habitual to alcoholism than those who have stable economic employment.(White, 2002)

International organizations like World Health Organization etc have been calling upon a more healthier society for all sections of the society. The constitution of India has not mentioned "health for all" as an explicit fundamental right as of now but various judgments provided by supreme court have time and again pointed out to the crucial significance of this right. Recently "Health for all" has been recognized as a human right and has been enshrined in the UHRD(Universal Declaration of human rights) as well.

According to UNDP right to health encompasses the following rights-

- Freedom- to control one's health and body without any interference
- Entitlements- access to quality health services, safe water and healthy food
- Healthy environment-including both natural as well as workplace environment
- Right to bodily integrity
- Freedom form torture, ill-treatment, and harmful practices
- Reproductive health-right to reproductive and sexual health, including maternal and child health
- Access to testing-like HIV testing, including among transgender and homosexual people

### *The case of Indian society*

The WHO report of 2007 titled "Social Determinants of Health" has mentioned India's case study presented by Ms Ganga Murthy. The report

mentions the constraints pertaining in the Indian healthcare system with special emphasis on inequalities related to access, health spending and health outcomes respectively.

*"Inequities in health outcomes and healthcare access are still prominent on a rural-urban, regional, provincial, and wealth basis; reasons for limited access to public healthcare services primarily as being non availability of human resources, vertical disease-centric approach, and a fragmented approach to healthcare, low funding (maintenance), lack of regional priorities and widening inequalities."(WHO, 2007)*

Though the report is of the 2000s, yet the issues highlighted in it with respect to India are valid in the present times as well. The findings of NFHS 5, corroborates with this.

Government initiatives to ensure equality of opportunity for all through provision of quality healthcare services to all includes Ayushman Healthcare Mission, schemes for aged populations, Janani Suraksha Yojna etc. Initiatives and work done by developmental societies like SEWA(Self employed women organization) related to the field of preventive and curative healthcare has been recognized in the WHO as well .

## *Conclusion*

Sociological account of medicine is largely based on the central argument that the medical knowledge performs some 'social functions' which are independent of whether it heals or cures- enforcing compliance with the

social roles in society, discipline the working class, administration and categorization of individuals, ensuring conformity of women to their feminine roles, etc among the others (White, 2002)

C.K Prahalad in his "*Fortune at the bottom of the pyramid: Eradicating poverty through profits, 2004"* provides that crafting of new innovative solutions for those at the bottom of the social stratification is the need of the hour. Business firms should design their products for meeting the requirements of these people and add value to their lives , along with earning profit simultaneously)(Sangwan et al,2019).

The same needs to be replicated in the healthcare sector if we are to achieve the SGD goal of "health for all" in the coming times. (Mixed method research is needed to understand the subject matter. Especially for country like India having numerous stratifications like caste, and rigid patriarchal structure, etc)

The pressing challenges of present times with respect to health equity and equality , as has been found by this paper ,are as follows:

1. Multidisciplinary research is required , having participation of people from the medical professions, sociologists, government policy makers, ethnographers, anthropologists, food nutritionists, etc.
2. Gap between field work and policy making and implementation has to be overcome.
3. Lack of data pertaining to health inequalities in Indian society and more research needs to be done on it. Datasets like national family health survey, etc need to be explored further though sociological dimensions to get greater clarity of the persisting issues.

Government initiatives to ensure health for all should take into consideration the social disparities prevalent in society. Various health related problems faced by people are not at the same scale and vary across employment, gender, caste , and religion lines. For providing quality healthy life to all of its citizens, the government needs to formulate policies tailored to requirements of different sections of society and thus a holistic approach is the way forward to ultimately reach the SDG 3 goal of "health for all".

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