Economics of Health and Healthcare
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Lecture – 47
Social Determinants of Health

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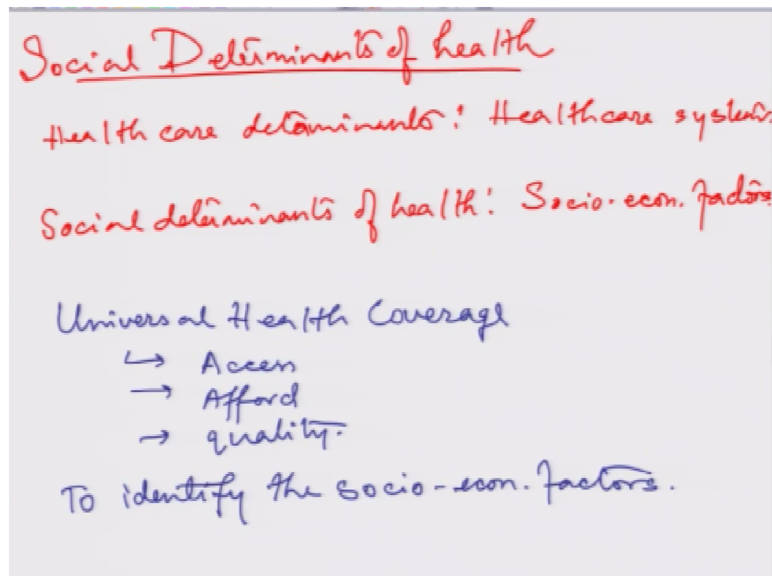

When we talk about the social determinants of health, when we talk about the social determinants of health, one is healthcare determinants, we have 2 components which come out of the healthcare system directly and another one is social determinants, yes and these are those socioeconomic factors, right and there are strong evidences that you know, spending can improve the healthcare but not only spending can improve the healthcare.

There are several, several other factors, we talk about the affordability, we talk about the accessibility and whenever we talk about that we, we just talk about that what is government share, what is the proportion of out of pocket expenditures, whether it is coming down or not what is government budget share towards the health expenditures and all or the public expenditures as a percentage of total health; health expenditure, health expenditure is a percentage of total consumption expenditure.

But expenditure is not everything, there are plenty of factors which play an important role in determining the health as a part of the development of an individual of a household or of a society overall, so why address social determinants of health that primarily, because we again

go back to our universal health coverage tropics coverage, where we have talked about accessibility, affordability and quality and all these things.

And at the same time you know that to identify the socioeconomic root cause of a problem because the Medical Sciences have often you know, realized that or they accepted that you know the medical, the clinical, the genetic factors are not the only factors which causes health adversities, there are socioeconomic factors as well and that is why we talk about the preventive measures and when we talk about the preventive measures, we talk about the awareness generation.

We talk about the you know, the community specific approaches yeah, we talk about the interpersonal communications techniques, so and the more we understand about its social construct about a diseases social construct, economic construct the you know, we can address the problem at the earliest and before the problem actually arrives, so and the problem can be solved at the short term as well within a short term as well.

So and it is important to change the behavioural aspects because the behavioural aspects are often associated with the culture, the culture is associated with the socioeconomic background of the person, so once we can you know, track that then probably, it is easier to change the behaviour towards or healthier this thing. The major determinants as we all know that it can be the income, income equality yeah we will come back to that.

Education, race, ethnicity, gender, occupation, the housing, the transportation, the access to services, the environment, the social support, so on and so forth, these are the basic you know major determinants, so what we all know therefore, whenever we talk about this determinants we are trying to; we are trying to marry between these socioeconomic aspects and the diseases right.

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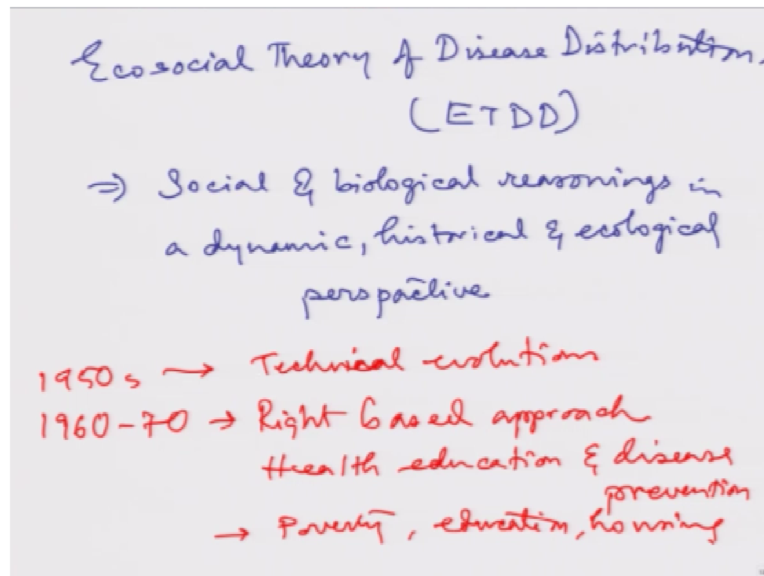

So, while we are trying to you know, connect both these socioeconomic aspects or the social determinants as well the health, then there is a theory called eco social theory of disease distribution yeah, which integrates the social and biological reasoning's in a dynamic, historical and ecological perspective. Dynamic is changing, historical; it has a historical root and ecology again with the environment with the understanding with the set up.

Here, the fundamental question is what is causing the problem, who is suffering the problem and whether people's, what is population tendency in terms of causing the problem, in terms of carrying the problem and you know, treating the problem and so, so we look at this both the social as well as the biological you know, constructs of this, of a particular problem. So, the historical; historically, you know the construct; construction of this eco social theory goes back to the 1950's, where you know this there were famines.

There were a high rate of infectious disease in several developing countries just got their independence are still are not have not got their independence and then, you know the but still the you know, the many countries are moving towards industrialization, the medical system is developing, the behaviour is changing, so the mortality is coming down that you know, there is a health transition.

So the, you know the hospitals and then, the technology has slowly started entering the society but mostly among the urban elite, so and slowly in 1960's and 70's, so it started in 1950's, in 1960's and 70's, it started becoming a right based approach that health is a right, yeah so health education and disease prevention was given importance as compared to you know, technology over here not basically, the technology maybe the technical evaluation; evaluations; technical evaluations, yeah health education and disease prevention.

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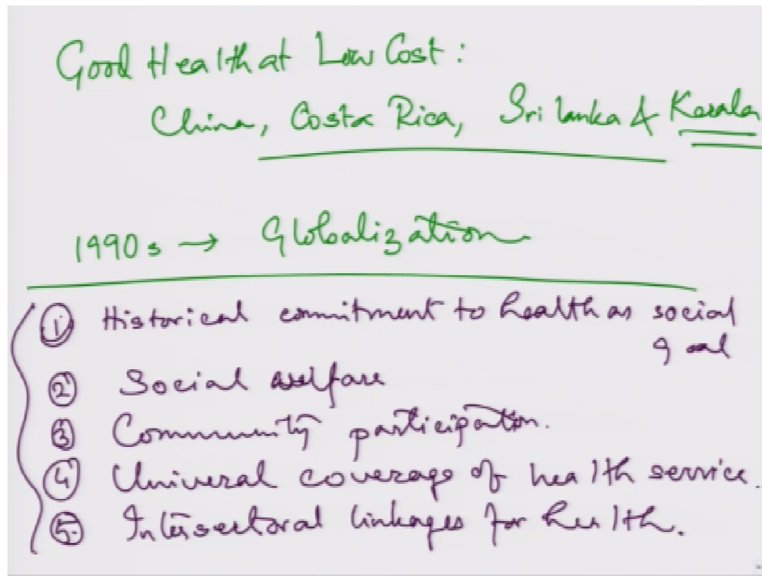

And then the poverty and education, housing, water, sanitation and all these things yeah, so and during this period slowly, we found that you know, there is a concept of good health at low cost, so certain countries have attained that which you know, caught the attention of this international bodies, so good health at low cost you know that means, at that age, the certain countries have derived the optimum health condition.

And these structures systems for that to attain that so, those countries are China, Costa Rica, Sri Lanka and Kerala, Cuba is a completely different system here, so we are not really bringing Cuba here Kerala in India, one particular state, so what they have done again, we know about Kerala, right the mechanisms are very, very different. China; the government pumped money in different ways you know.

Sri Lanka; it has lot of awareness generation, Kerala is a societal movement is basically, again a kind of you know development first ideology that is a Kerala model and then in the 1990's, the health and development debate moved towards globalization, yes the impacts of globalization in different countries both in developed countries as well as in developing countries.

So, to 5 you know, social and political factors to make good health at low cost could be number 1; historical commitment, 2; health as social goal, social welfare orientation, social welfare orientation, community participation, universal coverage of health services across all groups, all politics you know socio economic groups, population groups and intersectoral linkage connecting public, private, NGOs, international organizations yeah, for health.

And this all can eventually lead to the equity you know, to attain the equity in terms of accessibility and affordability of quality healthcare services. Now, when we talk about the equity, we are talking about that efficient outcome with or the best health outcome with limited wastage of resources, right that is the efficiency and with to attain that if the distribution allocative efficiency is attained you know, the technical efficiency can also be attained then we can bring in this equity.

Because then, the money allocation will be used at the best way the; you know the capital at the best way, then there we can know ensure the accessibility and affordability as well for those who really need it.

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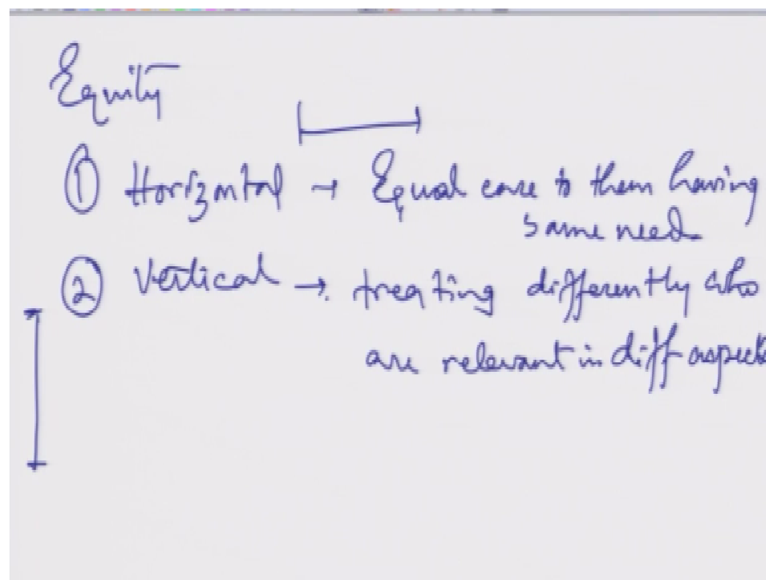

And then this equity can be of 2 types; one is horizontal equity or inequity, 2 is vertical, it is like equal care to them having same need, no discrimination right, everybody has same need, so they will be given the same care; same type of care and then vertical you know, the vertical you know, this is horizontal right, so treating differently who are relevant in different aspects that who has different demands or different necessities treat them differently, right.

This is the both equity and vertical, so not only we across the groups also within the groups there can be inequality, so we need to address both of them you know across and within.

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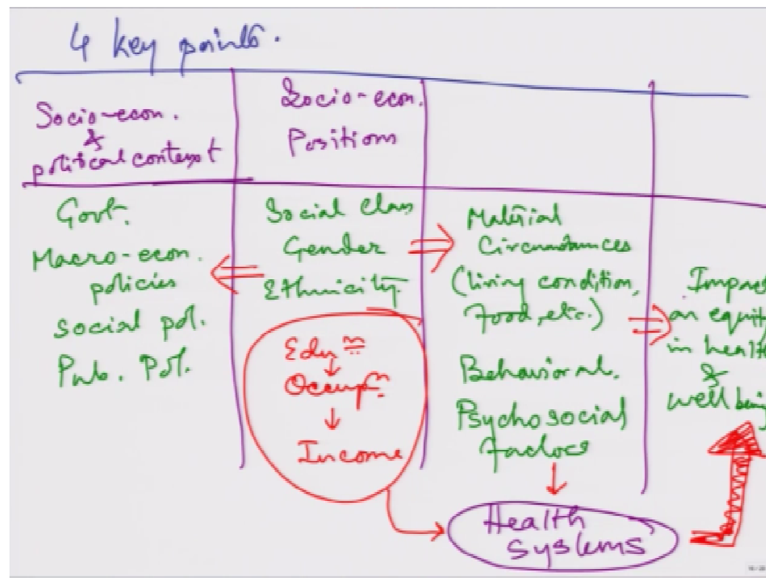

So, the 4 key points to reduce inequality can be you know, the number 1, so if the 4 key points we talk in terms of reducing inequality, then you know it should be reduce inequalities in power prestige, so I am not just writing down, so there are basically 4 key points; one is reduce inequalities in power, prestige, income and wealth because all can attain the health or the better health.

Number 2 can be trying to decrease the specific exposure towards the health adversity or the you know, the causes which can lead to health adversity of a particular problem or you know can lead to a more sufferings of a disadvantaged group and then lessen the vulnerability of disadvantaged group that provide better sanitation, better housing facility, better transportation, better walking condition.

And by intervening through health care you know educating them that about the lifestyles, about the; about the conditions which can, which can lead to their health adversities as well as to prevent which, which can prevent their further degradation of their health care as well as the they are; because if they know that health care is causing me the poverty, then probably to reduce the you know, healthcare induced poverty.

So, these are the 4 key points and then, we know if we look at these social determinants of health or community and social determinants of health framework, then you know it has also been said that because of the failure of Millennium Development goals, we had set certain levels of goals to attain in 2015 and you know in that in those Millennium Development Goals, they were mainly, there were 7 explicit areas you know, peace, health, protecting the environment.

And also total there were 8 goals, 18 targets and 48 indicators right 8 goals, 18 targets, 48 indicators under Millennium Development Goal which was designed in 2002.

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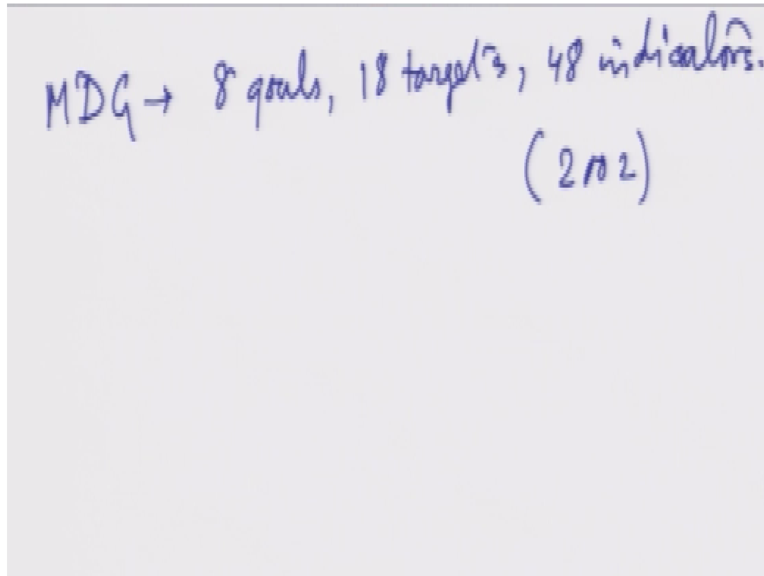

So, I will come back to this Millennium Development Goal, 8 goals, 18 targets, 48 indicators and then they talk about eradicate extreme hunger and poverty achieve a primary education empower women to reduce child mortality, reduce maternal mortality, HIV AIDS, you know environmental sustainability and partnership among development, these are the basic 8 goals you know and it has been stated in 2002.

But most of the countries failed to achieve these goals or the you know, the targets based on these 48 indicators in by 2015 and once they failed to achieve that then, it says that this you know failure has induced more inequalities across countries or within countries and especially in terms of development or a health, so the equity has been a real challenge for many countries and so, when we you know look at this CSDH framework, the first thing come to our mind anyways, before again coming back to CSDH, after MDG that is why they have moved to the sustainable development goal.

And in sustainable development goal, what we find is; you know we have total 17 goals and in under those 17 goals, we again talk about mostly you know inclusion and all and we talk about environmental sustainability, reduce poverty you know better, you know empowerment for the women, empowerment for the elderly people, occupation, so all these total 17 goals all together so and which look at the sustainability conditions.

So, basically not predetermined indicators and whether we are achieving that or not so, it is a little relaxed you know, so that is all about sustainable development goals as comparison to

MDG; MDG is over and we have not really done very well in most of the countries across the globe. So, when we come back to our CSDH and so, we need to you know, have 4 compartments, the first one is the socioeconomic and political context.

Here comes the government, the macroeconomic policies, the social policies like say, the government, macroeconomic policies, social policies, public policies you know all these, yeah public policies, so under this we have seen after this, after this we, we set up our socioeconomic and political context you know, we have this socioeconomic, we need to think of this socioeconomic positioning right.

So, socioeconomic positions and in this socioeconomic positions, we have social class, gender, class means in terms of occupation mainly, yeah, ethnicity; it can be castes, it can be religion and then, we can separately you know, prominently talk about education, occupation and finally, so this is like this yeah and finally, income which is easier to understand, yeah and otherwise these socioeconomic positions will determine these you know, the policy makings, the policy makings cannot, we learnt right in that public policy or the public good and all.

When we are studying, we learned that the government has to do a situation analysis, then the budget distribution, then monitoring and evaluation, implementation, monitoring evaluation and all these things, so and then when they do; need to do a situation analysis that is the analysis of this socioeconomic positioning and then, you know this, this also determine, this also determine the; here it is straight away go to here.

The material circumstances that is the living condition, food and the behavioural aspects here, so we can keep the behavioural aspects separately; behavioural aspects and then the last one is psychological factors, here or psychosocial factors because you know, the social; with the social class, the psychosocial factors will vary with gender, the psychosocial factors will vary and then this percolates down to the health systems, how it will be utilized.

And finally, impact on equity in health and well-being, so again this leads to this, this leads to this, this leads to this, right and this is my social and determine; social determinants of health of framework, so we need to understand the socioeconomic positions, which deals with the socioeconomic and political context and policy makings and then, also the at the micro level, the behaviour, the material context, the psychosocial aspects which determine the health systems and utilization.

And finally, resulting into the health outcomes yeah, so thank you very much in our next class, we will continue with the development aspects, thank you.