



# **SOCIOLOGY OF HEALTH AND WELL-BEING**

**COURSE CODE: M21SO06DE**  
Postgraduate Programme in Sociology  
Discipline Specific Elective Course  
Self Learning Material



SREENARAYANAGURU  
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**SREENARAYANAGURU OPEN UNIVERSITY**

The State University for Education, Training and Research in Blended Format, Kerala

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## Pathway

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Semester - IV

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Postgraduate Programme in Sociology

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# MESSAGE FROM VICE CHANCELLOR

Dear learner,

I extend my heartfelt greetings and profound enthusiasm as I warmly welcome you to Sreenarayanaguru Open University. Established in September 2020 as a state-led endeavour to promote higher education through open and distance learning modes, our institution was shaped by the guiding principle that access and quality are the cornerstones of equity. We have firmly resolved to uphold the highest standards of education, setting the benchmark and charting the course.

The courses offered by the Sreenarayanaguru Open University aim to strike a quality balance, ensuring students are equipped for both personal growth and professional excellence. The University embraces the widely acclaimed "blended format," a practical framework that harmoniously integrates Self-Learning Materials, Classroom Counseling, and Virtual modes, fostering a dynamic and enriching experience for both learners and instructors.

The university aims to offer you an engaging and thought-provoking educational journey. The Postgraduate Programme in Sociology naturally follows from the undergraduate programme. It mainly focuses on theories and practical applications. The programme uses vivid examples to make the subject interesting and relevant to learners. By combining academic content with empirical evidence, the programme becomes both unique and practical. The Self-Learning Material has been meticulously crafted, incorporating relevant examples to facilitate better comprehension.

Rest assured, the university's student support services will be at your disposal throughout your academic journey, readily available to address any concerns or grievances you may encounter. We encourage you to reach out to us freely regarding any matter about your academic programme. It is our sincere wish that you achieve the utmost success.



Regards,  
Dr. Jagathy Raj V.P.

01-05-2025

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# Basic Conceptual Understanding

**BLOCK-01**



## Health: Basic Concepts

### Learning Outcomes

Upon reading this unit, the learner will be able to:

- ◆ comprehend the concepts of health, well-being and Happiness Index
- ◆ familiarize themselves with the concepts of Standard of Living, Quality of Life, and Physical Quality of Life Index
- ◆ acquaint with the concepts and terminologies related to disease and Social Epidemiology

### Background

What do we mean by health, ill health, disease, and pathology? Why do sociologists study health and health behavior? These are the central questions this block will address in the coming units. At an individual level, ill-health often appears to strike randomly. However, at the population level, it is widely recognized that health is closely linked to circumstances and ways of living. Factors such as poverty or prosperity, urban or rural environments, work or unemployment, stress or contentment—all significantly influence health outcomes. What promotes a 'healthy' lifestyle? To what extent is an individual responsible for their own health? These pressing questions are at the forefront of public discourse today.

To explore these issues, it is essential to define health first. As demonstrated by extensive literature over the past few decades, there is no straightforward or universally accepted definition. Disease and physiological states can often be identified and measured—albeit with difficulty in large-scale population surveys—but health encompasses more than just the absence of disease. Health and illness are both biological and social phenomena.

From this multi-dimensional perspective, we must approach health, illness, lifestyle, and broader indices like the Happiness Index, the Standard of Living, and the Physical Quality of Life Index. This unit aims to equip you with a critical perspective on these concepts, enabling a deeper understanding of the complex relationships between health and society.



## Keywords

Bio-medicine, Wellness, Happiness Index, Social health, Epidemiology

## Discussion

### 1.1.1 Concept of Health

- ◆ *WHO's definition*

The World Health Organization (WHO) defines health as a “state of complete physical, social, and mental well-being, and not merely the absence of disease or infirmity.” This comprehensive view underscores that health is not just a physical condition but also depends on mental stability, emotional balance, and a supportive environment. While broad, this definition is not new, echoing classical notions such as Plato’s model of health as harmony among bodily processes or Galen’s concept of disease as a disturbance of equilibrium. Health, therefore, must be understood as multi-dimensional and relative, incorporating both objective and subjective elements.

- ◆ *Multidimensional concept*

In the biomedical model, which underpins much of modern medicine, disease is typically defined as deviations of measurable biological variables from established norms or the presence of identifiable and categorized forms of pathology. This approach also informs lay perceptions of health and illness. However, as historians and philosophers of medicine have noted, even this ostensibly clear-cut view is fraught with complexities. The classification and definition of disease are, to some extent, socially constructed, and the concept of ‘normality’ is inherently relative and value-laden. The concept of health is multidimensional and can be understood from physiological/biological, social/cultural, and psychological perspectives. The definition of health and illness varies significantly depending on whether one relies on “objective scientific” criteria or emphasizes people’s subjective experiences.

- ◆ *Anthropological view*

Sociologists and anthropologists have explored how individuals perceive and define their health, leading to what is known as the “lay model of health.” This perspective highlights that people’s understanding of health and illness often diverges from scientific definitions. For instance,



functionalists view health as the ability to perform daily activities and fulfill societal roles. However, how health and illness are defined varies significantly across cultures, age groups, occupations, and genders.

◆ *Cultural context*

Mildred Blaxter (1903, 1990) has found that many people define health simply as the “absence of disease,” reflecting a straightforward and practical approach. Similarly, Howlett et al. (1992) documented ethnic differences in the perception of health. They observed that Asians often viewed health in a spiritual or holistic sense, while Africans associated health with physical strength and illness with misfortune or bad luck. These findings demonstrate how cultural contexts shape health definitions.

◆ *Moral dimension*

Helman also emphasizes the importance of understanding the cultural context of illness. People’s reactions to illness, death, or misfortune are deeply influenced by the culture in which they were raised or adopted. This cultural “lens” shapes how they perceive and interpret their experiences. To fully understand health and illness in a society, it is crucial to explore its social organization. This includes examining how individuals recognize themselves as ill, how they communicate this illness to others, the characteristics of the people they turn to for help, and how the illness is managed within that cultural context. In addition to cultural differences, the moral dimension of health has been explored. Conrad (1994) discussed the stigma attached to certain illnesses, such as sexually transmitted diseases, which carry not only a physical burden but also societal judgment and shame. Such moral and social aspects further complicate how health and illness are understood and experienced.

◆ *Multifaceted*

Given these variations, it becomes clear that health is not a straightforward concept. Instead, it is multifaceted and deeply influenced by culture, personal experiences, and societal norms. This complexity challenges the idea of a single, universal definition of health, emphasizing instead the need for a contextual and inclusive understanding of this essential human condition.

### 1.1.1.1 Disease, Illness and Sickness

Health is commonly understood as either an ideal state of well-being or simply the absence of disease. On the other hand, illness refers to the subjective experience of feeling unwell. Illness is what an individual perceives as being “wrong” with them, which may prompt them to visit a doctor.

◆ *Terminological differences*

Disease, however, is the medical diagnosis or condition identified by the doctor during or after that appointment. According to Cecil Helman (2007), many factors contribute to a person defining themselves as ill. These factors are often subjective and may include noticeable changes in appearance (like sudden weight loss), unusual bodily functions (such as frequent urination or diarrhea), issues with specific organs (like a racing heartbeat or headaches), or emotional states (such as feelings of depression or anxiety). The term “sickness” combines the subjective feeling of illness and the objective diagnosis of disease. It also refers to the social role that arises once an illness is diagnosed. This role comes with certain rights (such as receiving care and sympathy) and obligations (like seeking treatment and striving to recover) that society assigns to the individual.

### 1.1.1.2 Different Approaches to Health

When someone feels unwell, they may initially consult a traditional healer, known as the medicine man, for remedies rooted in indigenous practices. If this does not resolve the issue, they might turn to Western scientific medicine, perhaps through a doctor who administers treatment in the form of pills or injections. If neither the traditional nor the Western approach works, individuals may seek solace in their indigenous spiritual beliefs. These approaches are often used simultaneously, with each healer unaware of the other’s involvement, reflecting a blending of traditional, modern, and religious health practices.

This example highlights the complexity of health as viewed through various approaches:

1. **The Ecological Approach:** This perspective sees health as a dynamic balance between humans and their environment. Illness, in this context, is understood as a disruption or maladjustment of the human body to environmental conditions. For example, poor sanitation or exposure to pollutants can lead to health problems.
2. **The Psychological Approach:** This viewpoint emphasizes the connection between the body and the mind. Health is influenced not only by physical conditions but also by an individual’s mental state and attitude. A positive outlook and good mental health are seen as vital for overall well-being.

**3. The Socio-Cultural Approach:** Health is viewed as a product of the broader social and community structure. Factors like cultural norms, economic conditions, and access to healthcare influence health outcomes. For instance, a community with strong social support networks might promote better health and quicker recovery from illness.

**4. The Functional Approach:** This approach defines health in terms of a person's ability to fulfill normal social roles and responsibilities. A healthy individual is someone who can actively participate in their community and meet the demands of daily life.

These varied perspectives reveal that health is not a simple, one-dimensional concept. Instead, it is shaped by a combination of environmental, psychological, social, and cultural factors, and the ways in which people approach illness and treatment often reflect these influences. Understanding these diverse frameworks allows for a more comprehensive view of health and healing across different societies.

◆ *Multi-dimensional concept*

### 1.1.2 Concept of Well-being

The terms *health* and *well-being* are often used interchangeably or in conjunction, but they have distinct meanings. *Well-being* encompasses a broader concept, usually described by scholars as a combination of factors such as standard of living, level of living, and quality of life. According to the Center for Disease Control and Prevention (CDC) in the USA, well-being is a subjective measure reflecting an individual's contentment with their life and social circumstances. This definition includes not only physical and mental health but also other determinants such as economic stability, social relationships, job satisfaction, and a sense of productivity.

◆ *Definition*

What exactly is wellbeing? Historically, the term "welfare," which dates back to the 14th century, referred to "journeying well" and was associated with happiness and prosperity. In the 20th century, welfare became linked to the welfare state and the assessment of needs, gaining a more objective and external meaning. In recent decades, new perspectives emphasizing agency, participation, and multidimensional poverty have revived older ideas of wellbeing, drawing from thinkers like Aristotle and the Buddha.

◆ *Wellbeing and welfare*

Wellbeing remains a contested concept. The *Oxford Companion to Philosophy* defines it broadly as "living and faring

◆ *Umbrella term*

well” or “flourishing,” linking it to happiness and a good life. Wellbeing is often categorized into objective wellbeing—measurable aspects like health and mobility—and subjective wellbeing, which reflects personal feelings and evaluations. Scholars have proposed detailed classifications of wellbeing, recognizing its complexity and plurality. While there is no universal consensus, wellbeing serves as an umbrella term that accommodates various related ideas. Wellbeing includes both the objective conditions of a person’s life and their subjective assessment of those conditions. Both aspects are shaped by social, cultural, economic, and political contexts, making wellbeing a relational and dynamic concept. It is not just an outcome but also a process influenced by societal interactions.

◆ *Wellbeing and development*

Wellbeing is an important topic in social sciences and policy discussions. It bridges academic disciplines and policy-making by fostering debate about what it means to live well. Wellbeing is deeply connected to broader ideas of development as “good change.” Historically, development has been viewed through an economic lens, emphasizing material wealth measured by income or national income per capita. Over the past two decades, however, this view has been challenged, leading to new ways of conceptualizing and measuring wellbeing.

◆ *Mental states*

Wellbeing is often reduced to mental states like pleasure or desire fulfillment, but physical, social, and political achievements (such as avoiding malnutrition, mobility, self-respect, and civil liberties) matter only if they affect utility. This focus on utility is problematic because it can be influenced by mental conditioning or expectations. Amartya Sen (1999) highlights that people’s satisfaction levels might not reflect their actual living conditions. For instance, a post-famine survey in India showed destitute widows with poorer health but higher subjective wellbeing than widowers.

◆ *Psychological and social factors*

The concept of wellbeing involves a person’s ability to function optimally, encompassing not just physical health but also a sense of engagement with their environment, confidence in setting and achieving important goals, and the motivation to overcome challenges. A healthy individual maintains vitality and thrives in their everyday surroundings. Therefore, the study of human wellbeing must consider not only physical needs but also the psychological and social factors that contribute to a person’s overall fitness.

◆ *Risk and security*

The balance between autonomous and dependent security affects wellbeing, linking social actors' perception of time, risk, and opportunity. Decisions about risk and agency today are influenced by future expectations. Predictability and security are key to wellbeing, with safety being a fundamental human instinct. The avoidance of fear, especially regarding safety, plays a significant role in wellbeing. Fear, commonly experienced as anxiety and panic, represents a form of ill-being. This fear is more pronounced in vulnerable populations who have little control over their lives, particularly the poor in resource-scarce environments. For these groups, fear and security are inversely related, where the presence of fear diminishes security. Fear often stems from uncertainty – uncertainty about resources to face challenges, fulfilling responsibilities to family and friends, and protecting oneself and others. Those with resources invest in reducing risks to wellbeing. In contrast, those without resources remain in fear, a common condition in poverty-stricken areas. The lack of resources is compounded by external uncertainties, perpetuating fear and insecurity.

◆ *Shocks*

Security and wellbeing also relate to risks, which can be shocks or hazards. Everyone faces shocks, but their impact varies based on factors like housing quality or subscription to insurance policies. For instance, the poor are more vulnerable to hazards due to less resistance and fewer resources to prepare. Predictable life events, like illness or social obligations (e.g., weddings, funerals), pose significant financial risks, especially for the poor. Wealthier families can manage these risks through savings and diverse income sources, but poorer families may sacrifice autonomy and deepen their dependence on others to meet these obligations, furthering their vulnerability.

◆ *Objective and subjective conditions*

### **1.1.2.1 Components of Well-being**

According to J. Allister McGregor, the concept of wellbeing can help reconnect different areas of development thinking and draw on broader social science insights to enhance our understanding of poverty dynamics. Wellbeing should combine both the objective conditions of a person's life and their subjective perceptions of their situation. It should not be seen merely as an outcome but as a state that emerges from the interaction between outcomes and processes. This interaction must be understood within the context of social, economic, political, cultural, and psychological influences.

Allister McGregor says wellbeing is arising from:

1. What a person has,
2. What they can do with what they have, and
3. How they think about what they have and can do.

He talks about three frameworks: 1) needs, 2) resources, and 3) quality of life. These allow us to reframe wellbeing in terms of:

1. The resources a person can access,
2. What they can achieve with those resources, particularly in meeting their needs and goals, and
3. The meaning they attach to their achievements and the processes they undergo. A critical part of this last dimension is the quality of life they believe they are attaining, which shapes their future strategies and aspirations.

According to him, five key ideas form the foundation of a new theory of human wellbeing:

1. The importance of social connections in human life,
2. Harm and needs,
3. The roles of meaning, culture, and identity,
4. The significance of time and processes, and
5. Resourcefulness, resilience, and adaptation.

#### **1.1.2.2 Focus on Human Well-being**

This concept emphasizes placing the 'human being' at the center of analysis, moving beyond structures like markets, states, or cultures to understand wellbeing from the perspective of real individuals.

1. **Human as a Social Being:** The concept asserts that understanding humans necessitates acknowledging their social nature, including their involvement in collectivities and societal structures that influence their wellbeing.
2. **Diversity and Social Structures:** It recognizes the diversity among individuals – based on gender, re-



ligion, ethnicity, etc. – and how these differences impact their interaction with social structures and their ability to negotiate wellbeing.

3. **Individual vs. Relational Wellbeing:** This type of analysis balances individualistic and relational approaches to wellbeing, arguing that these perspectives should not be seen as opposites but as complementary aspects of human existence.
4. **Theory of the Person:** A theory of the person, as a social being, is central to understanding wellbeing, emphasizing relationships and communication as essential components of human needs.
5. **Resources and Social Context:** The meaning and use of resources are understood through the context of specific relationships, where social structures shape their realization and outcomes.
6. **Eudaimonic Perspectives:** Relatedness is fundamental in eudaimonic wellbeing perspectives, such as Ryan and Deci's Self-Determination Theory, highlighting humans as inherently active and relational beings.
7. **Critique of Social Sciences:** The critique focuses on the reductionist approach in social sciences, which often overlooks the holistic nature of individuals, resulting in a loss of moral and subjective dimensions in understanding the human.
8. **Human Ontology:** The wellbeing framework calls for an ontology that recognizes humans as whole persons with biological, psychological, and social dimensions, actively engaged in meaning-making within their social contexts.

### 1.1.2.3 Other Components of Wellbeing

#### a. Harm and Needs

This framework highlights the significance of acknowledging the unbearable suffering and premature death many poor individuals face, which is often overlooked in poverty studies. The Doyal and Gough Theory of Human Need (THN) and Self-Determination Theory (SDT) emphasize the objective link between unmet basic needs and serious harm,

◆ *Dimensions of need*

affecting both physical and psychological wellbeing. These theories argue that harm arises from cognitive and social processes as well as direct actions, challenging the notion of needs as purely objective.

### **b. Roles of Meaning, Culture, and Identity**

Meaning, shaped by culture and relationships, is central to understanding wellbeing. Both THN and SDT stress that wellbeing is socially constructed and deeply tied to cultural and relational contexts, advocating for a nuanced approach to analyzing harm and needs within societal structures. Individuals internalize cultural values to fulfill psychological needs, linking these to identity and autonomy. Autonomy, defined as self-endorsement of behavior, varies across cultures, underscoring the role of social constructs in shaping what is considered normal or acceptable. This approach integrates abstract concepts with concrete cultural manifestations, facilitating a comprehensive understanding of wellbeing.

◆ *Social aspect*

### **c. Resourcefulness, Resilience, and Adaptation**

Allister McGregor et al. also emphasizes resourcefulness, resilience, and adaptation, highlighting that even people in extreme poverty can adopt strategies for survival and satisfaction. The Resource Profiles Framework suggests that resources extend beyond material assets to include relationships and social connections. Studies, like those by Biswas-Diener and Diener in Calcutta, show that the poor report levels of satisfaction close to those of middle-class groups, particularly in social relationships. However, thinkers like Amartya Sen warn against over-relying on self-report, as they may reflect adaptive expectations rather than true well-being. Adaptation helps people cope with harsh conditions, and subjective well-being is maintained through resilience and resourcefulness.

◆ *Relationships and connections*

## **1.1.3 Happiness Index**

The happiness index is a comprehensive tool that evaluates happiness, well-being, and aspects of sustainability and resilience. It allows the collective happiness of a nation to be analyzed through this developmental framework. The happiness index, also known as the “life ladder,” is measured using key variables such as income, freedom, trust, healthy life expectancy, social support, and generosity. The results are averaged into a single value, contributing to

◆ *Measurement and ranking*

the World Happiness Report (WHR). The United Nations' Sustainable Development Solutions Network publishes this annual report, which includes articles and rankings based on people's self-assessed life satisfaction. The WHR, first released in 2012, serves as a foundational document for the UN's focus on well-being and happiness, promoting a new economic model. The report outlines global happiness levels, the factors influencing happiness and misery, and policy implications derived from case studies. A recent survey indicates that in India, financial stability and physical well-being are the top reasons for happiness. In the WHR of 2024 Finland tops the list followed by Denmark, Iceland and Sweden. India is placed in 118th position

◆ *Gross National Happiness*

Gross National Happiness (GNH), a term coined by Bhutan's 4th king, guides the country's governance, measuring development through life satisfaction. GNH focuses on four pillars: sustainable socio-economic development, environmental conservation, cultural preservation, and good governance. The GNH index uses thresholds to categorize people as unhappy, narrowly happy, extensively happy, or extremely happy based on their sufficiency in these areas. The overall GNH index, with a cutoff of 66% sufficiency, implies that individuals are considered happy if they meet sufficiency in at least 66% of the indicators. In Bhutan, the GNH was calculated at 0.743. It measures life satisfaction, happiness, and several key areas such as psychological well-being, health, time balance, community, social support, education, arts and culture, environment, governance, material well-being, and work.

The qualities measured in each domain are:

1. **Psychological Well-Being:** Optimism, sense of purpose, and feeling of accomplishment.
2. **Health:** Energy levels and ability to perform daily activities.
3. **Time Balance:** Enjoyment, feeling rushed, and leisure time.
4. **Community:** Sense of belonging, volunteerism, and feeling of safety.
5. **Social Support:** Satisfaction with friends and family, feeling loved, and loneliness.
6. **Education, Arts, and Culture:** Access to cultural and

educational events and diversity.

7. **Environment:** Access to nature, pollution, and conservation efforts.
8. **Governance:** Trust in government, perceived corruption, and competency.
9. **Material Well-Being:** Financial security and meeting basic needs.
10. **Work:** Compensation, autonomy, and productivity.

**Domains and Indicators**

**Table 1.1.1 : Domains and Indicators**

<b>Domains</b>	<b>No. of Indicators</b>	<b>Indicators</b>
<b>Psychological Well-being</b>	4	- Life satisfaction - Positive emotion - Negative emotion - Spirituality
<b>Health Aspects</b>	4	- Mental health - Self-reported health status - Healthy days - Long-term disability
<b>Time Management</b>	2	- Working hours - Sleeping hours
<b>Educational Standards</b>	4	- Literacy - Educational qualification - Knowledge - Values
<b>Cultural Diversity</b>	4	- Language (speak native language) - Socio-cultural participation - Artisan skills - Etiquette
<b>Good Governance</b>	4	- Political freedom - Service delivery - Political participation

<b>Community Vitality</b>	4	- Social support - Donation of time and money - Community relationships - Safety - Family - Victim of crime
<b>Ecological Diversity and Resilience</b>	4	- Pollution - Environmental responsibility - Public transport access - Wildlife conflict
<b>Living Standards</b>	3	- Assets - Household income - Housing quality
<b>Total</b>	<b>33</b>	

### 1.1.4 Standard of Living and Quality of Life

In social science, the standard of living refers to what individuals or groups aspire to in terms of goods and services. It can also refer to the actual goods and services they consume, sometimes called the “level of living” (what they have) as opposed to the “standard” (what they wish for). This includes both personal purchases and publicly provided services or environmental factors that improve well-being. Some social scientists suggest that people’s desired standard of living is shaped by the spending habits of those with similar incomes. As a result, a person’s standard of living might shift when their income changes.

- ◆ *Desire for a good life*

Comparing living standards between different groups or countries is complex. It is essential to differentiate between the average consumption level and its distribution within a group. For instance, if the average consumption rises but wealth inequality increases, it does not necessarily mean everyone is better off. Comparing living standards between countries with varying degrees of income inequality is also tricky. Generally, the gap in living standards is more significant between developed and less-developed countries than between developed nations. These difficulties persist regardless of the indicators used to measure living standards. Beyond income, other useful indicators might include protein intake, life expectancy, and access to essential services like clean water. However, making comparisons across countries

- ◆ *Problem of comparison*

using these indicators can be difficult, particularly in very poor countries with unreliable data.

◆ *Monetary measures*

Monetary measures of living standards often overlook important factors such as nutrition and life expectancy. They also face challenges like distorted pricing and government manipulation of exchange rates, complicating international comparisons. Adjusting for price changes over time is also challenging, especially when inflation rates differ between countries. When the prices of goods and services vary greatly between countries, making fair comparisons based on consumption becomes even harder.

◆ *Challenges of assessment*

Quality of Life (QoL) refers to how individuals perceive their position in life within the context of their culture and value systems and in relation to their personal goals, expectations, standards, and concerns. It is a broad concept influenced by various factors, including physical health, psychological state, independence, social relationships, and environmental features. Due to growing international interest in QoL, there is an increasing need for measures that are applicable across different cultures. However, assessing QoL across cultures presents several challenges. The concept of QoL or the methods used to measure it might not be easily transferable between cultures, and practical difficulties can arise when applying these measures in developing countries.

◆ *Change in concepts*

QoL has a complex history, with contributions from fields such as psychology, politics, economics, and philosophy. It became a key area of study in sociology and social policy in the latter half of the 20th century. Later, health scientists and psychologists adopted the term, defining QoL in terms of individuals' perceptions of their health status, leading to the concept of Health-Related Quality of Life (HRQoL).

◆ *Health-Related Quality of Life*

Sociology and social policy have a long history of using QoL indicators across different cultures and nations, mainly through objective indicators. Subjective indicators of QoL, focusing on satisfaction with various life domains (such as material, financial, social, and political), have also been included in population surveys. Initially conducted in the United States and Europe, these surveys have expanded to Latin America, Asia, and Africa. Over the past 25 years, HRQoL has gained attention from researchers and practitioners, partly due to the demand for cross-national QoL research by international clinical trials and organizations

like the World Health Organization involved in healthcare planning and interventions.

◆ *Anthropology and QoL*

Anthropology has also significantly contributed to understanding the cultural specificity of health and QoL. It highlights that illness involves the meaning individuals attribute to their diseases, shaped by cultural schemas. This is particularly evident in “folk illnesses” or “culture-bound syndromes,” such as *susto* in Latin America, *koro* in China and Southeast Asia, and *anorexia nervosa* in Europe and North America. Conversely, some common medical conditions may not be recognized as illnesses due to their high prevalence in certain cultures, such as malaria among the *Mano* in Liberia.

◆ *Evolution of research*

Research on health-related quality of life (QoL) began in the mid-1970s, led by health scientists and psychologists, to track individuals’ perceptions of their health. This development was driven by the need for more sensitive measures to compare treatments for chronic illnesses and to determine their cost-effectiveness. Health-related QoL measures assess people’s perceptions of their health through both subjective questions about satisfaction and emotions and objective self-reported questions about symptoms and functional status. Quality of Life research has been ongoing since the 1960s, but it remained a specialized area, mainly focused on wealthy countries. The 1970s introduction of the Physical Quality of Life Index (PQLI) had limited influence and did not last long. It was not until the 1990s, with the rise of the Human Development approach led by the United Nations Development Programme (UNDP), that a more comprehensive focus on quality of life became widespread in studies of low-income countries. Significantly, the UNDP’s work has evaluated both low-income and high-income countries within the same framework.

The World Health Organization Quality of Life Group (WHOQOL), established in 1991, is perhaps the most successful cross-national QoL research program. WHOQOL defines QoL as “an individual’s perception of their position in life within the context of their culture, value systems, goals, expectations, standards, and concerns”. They developed a common international protocol for creating generic QoL profile measures, with input from all fifteen original WHOQOL centers. These centers contributed to defining the facets that make up the six domains of QoL, using focus groups to draft locally appropriate questions

◆ *WHOQOL*

about people's QoL. The WHOQOL program has shown that, while QoL levels differ across countries, the structure of QoL domains has high cross-cultural validity, indicating a significant degree of universality. Nonetheless, the program faces challenges, such as focusing only on health-related QoL without directly addressing autonomy.

◆ *The concept*

### 1.1.5 Physical Quality of Life Index

The Physical Quality of Life Index (PQLI), created by Morris David Morris in the mid-1970s, was developed as a response to dissatisfaction with the use of Gross National Product (GNP) as a measure of development. The PQLI aimed to provide a more accurate reflection of the standard of living and quality of life in nations by incorporating key social and health indicators. Although it represents an improvement over GNP, it still faces criticisms due to the complexities inherent in quantifying quality of life and the overlap between certain indicators, particularly infant mortality and life expectancy.

◆ *Calculation*

The PQLI is calculated using an average of three key indicators: basic literacy rate, infant mortality rate, and life expectancy at one year, with each factor equally weighted on a scale from 0 to 100. These indicators are intended to reflect the well-being of a population by focusing on the most fundamental aspects of quality of life. The index was developed in response to the realization that traditional measures of economic growth, like GNP, failed to capture the well-being of a nation's citizens. The PQLI, therefore, attempts to provide a more holistic measure of development.

◆ *Indicators*

Life expectancy, which reflects the average number of years an individual is expected to live, is one of the key components of the PQLI. For example, according to the 2011 census, the average life expectancy in India was 66.8 years. Infant mortality, defined as the number of newborns who die within the first year of life per 1,000 births, is another critical measure. In India, the infant mortality rate was 47 per 1,000 births, according to the 2011 census. The third indicator, the basic literacy rate, measures the proportion of individuals above the age of seven who can read and comprehend in at least one language. In India, this rate stood at 74.04%, according to the 2011 census. These three indicators are scored on a scale of 1 to 100, with higher scores indicating better performance. The PQLI is then computed by averaging these scores, giving equal weight to each indicator.



◆ *Comparison*

Despite its advantages, the PQLI has certain limitations. One of its strengths is that it offers a clearer understanding of a country's overall well-being, especially in terms of social development and the effectiveness of welfare measures. It allows for cross-country comparisons, which can help poorer nations identify areas of improvement. Countries that score well on the PQLI are generally seen as having successful economies with effective welfare policies. Moreover, the three indicators—life expectancy, infant mortality, and literacy—are widely considered reliable measures of a population's health and education.

◆ *Strengths and drawbacks*

One significant limitation is its narrow focus on only three indicators, which leaves out other important aspects of quality of life, such as employment, housing, justice, and access to social services. Furthermore, the PQLI assigns equal weight to each of the three indicators, but it is unclear why all indicators should be considered equally important. For example, while life expectancy and infant mortality are closely related, they do not necessarily carry the same weight in reflecting the overall quality of life. Also, the PQLI does not account for structural changes in a country's economy, which may affect its development in ways that are not captured by these three indicators alone.

◆ *Limitations*

This index serves as an important tool for comparing the well-being of different nations, providing insight into social and health-related development. It highlights the relationship between key health and education indicators and the overall standard of living. However, it is important to recognize its limitations, particularly its narrow focus and the equal weighting of its components, which may not fully capture the complexities of quality of life. Despite these challenges, the PQLI remains a valuable tool for assessing and comparing the social development of nations, helping to guide policy and remedial actions, especially in less developed regions.

◆ *Defenition*

Anthropology defines illness as the subjective experience of feeling unwell, something that negatively impacts an individual's daily life and activities. Disease, on the other hand, refers to the objective and harmful physical changes in the body, which are typically diagnosed by a physician. Interestingly, one can have a disease without experiencing

### **1.1.6 Concept of Disease & Social Epidemiology**

illness, and conversely, one can feel ill without being diagnosed with a disease.

◆ *Social production of diseases*

Amartya Sen (2002) conducted a comparative study of perceptions of health in India and the United States. He found that higher levels of education corresponded to increased reports of illness and greater demand for healthcare. This suggests that education influences people's awareness of their health and access to medical care, which can be vividly seen in the health-seeking behaviour in the state of Kerala. Diseases are not merely the result of biological or natural factors; they are deeply influenced by social conditions. The way diseases are produced and distributed in society is shaped by factors such as class, gender, and ethnicity, as well as how medical professionals define certain conditions as diseases. This indicates that medical knowledge is not purely scientific but is shaped by and shapes the societal context in which it develops.

Sociologists provide different explanations of how diseases are socially shaped. For example:

- ◆ Marxist theorists emphasize the role of class inequalities.
- ◆ Feminist thinkers focus on patriarchy and gender-based disparities.
- ◆ Foucauldian scholars highlight how administrative systems and professional practices influence health.
- ◆ Those studying ethnicity analyze the impact of racism on health outcomes.

Environmental pollutants play a significant role in causing diseases such as cancer. Their unrestricted use, aimed at increasing productivity and profitability, has severe consequences. For instance:

- ◆ We all know about the Endosulfan tragedy in the Kasaragod district of Kerala. The tragic case of endosulfan poisoning in Kerala highlights how environmental factors can influence the production of diseases. The persistent aerial spraying of this pesticide led to severe health consequences, including skeletal and congenital abnormalities in humans and animals in Kerala.

- ◆ A study in Ireland (1980–1990) found a significant increase in testicular cancer, non-Hodgkin’s lymphoma, and leukemia among semi-skilled farm workers exposed to pesticides. Those using protective measures experienced lower incidences of these diseases.

◆ *Context*

These findings underline how social and economic decisions, such as industrial practices, shape health risks. Sociologists view diseases as outcomes of social organization. Poor living and working conditions lead to poorer health outcomes, and individuals from lower socioeconomic groups often experience shorter life spans compared to those at the top of the social hierarchy. Evidence shows that diseases rarely arise from purely biological causes; instead, social factors significantly influence health. For example:

- ◆ Standards of living, workplace conditions, and gender roles shape health outcomes.
- ◆ Ethnic hierarchies and social inequalities further exacerbate health disparities.

◆ *Biological predisposition*

While biological predispositions and genetic risks exist, their transformation into actual health conditions is mediated by factors like politics, economics, gender, and ethnicity. Individual lifestyle choices, often cited as causes of diseases, are themselves shaped by social contexts. Thus, focusing solely on lifestyle ignores the broader social factors that influence individual actions. One of the dominant explanations for the prevalence of diseases is the belief that people adopt unhealthy lifestyles, making them individually responsible for their illnesses. According to this perspective, choices such as poor diet, smoking, and lack of exercise are the primary causes of ill health. While this explanation might seem straightforward and logical, it oversimplifies a complex issue and shifts the blame onto individuals, ignoring the wider social and structural factors that shape these choices.

A striking example of this flawed reasoning can be seen in the health issues faced by Indigenous communities in Australia, particularly the higher rates of diabetes. Policymakers and commentators often argue that Aboriginal people have diabetes because they freely choose unhealthy Western foods like potato chips, soft drinks, and alcohol. They further claim that Aboriginal people are genetically “not programmed” to process these foods and that their

- ◆ *Blaming of Indigenous people*

culture promotes indifference or laziness toward health. This reasoning creates a harmful equation, suggesting that poor food choices are their fault, the inability to process Western food is their biology's fault, and health indifference is their culture's fault. This type of reasoning creates a narrative that unfairly places the blame for malnutrition on tribes, suggesting that their condition results from not consuming proper food!

### 1.1.6.1 Social Epidemiology

- ◆ *Doctrine of specific etiology*

The work of Louis Pasteur, a French chemist, and Robert Koch, a German doctor, in the 19th century led to several key breakthroughs in medicine. Their contributions advanced the understanding of disease causes and paved the way for the development of vaccines, anesthetics, and antiseptics. Their work demonstrated that specific diseases could be caused by specific microorganisms. This led to what René Dubos, a French-American microbiologist and environmentalist (1961), termed the "doctrine of specific aetiology." According to this view, illnesses were understood as distinct clinical conditions, each with unique pathological features caused by a particular agent. The classical era of epidemiology successfully applied this model to various diseases caused by microorganisms, viruses, nutrient deficiencies, toxins, or other specific agents. The focus on identifying specific causes for distinct pathologies proved highly effective in addressing many health challenges of the time.

- ◆ *Multifaceted causes*

However, the traditional approaches of epidemiology have become increasingly complex in modern Western societies, where health issues are often chronic and degenerative. It is now widely recognized that most diseases result from multiple and interconnected factors. Modern knowledge highlights the roles of genetic predispositions, psychosocial influences, and individual susceptibility in shaping health outcomes. Addressing these multifaceted causes often requires more complex explanations, even though they may be less precise or harder to demonstrate. This shift marks a significant evolution in the understanding of health and disease, emphasizing the interplay of biological, psychological, and social factors.

Epidemiology, which originally focused on public health and collective well-being, has shifted towards an individualistic approach that emphasizes lifestyle and risk factors. This transformation reflects broader political

◆ *Multifaceted causes*

and economic changes, particularly the retreat from state-provided services and the promotion of individual responsibility under neoliberal policies. Social capital theorists argue that strong communities, built on resilient social relationships, contribute to healthier populations and reduce state expenses. However, such communities are difficult to form in contexts of economic inequality.

◆ *State intervention*

Historically, epidemiology played a crucial role in public health reforms, demonstrating that individual health cannot be left entirely to personal responsibility. For example, during Britain's military campaigns in the Boer War in South Africa and World War I, the poor health of working-class recruits highlighted the need for state intervention. This recognition, along with the economic hardships of the Great Depression, contributed to the development of the Welfare State. From the post-World War II period to the 1970s, governments adopted interventionist policies to mitigate the effects of market-driven inequalities, improve working and living conditions, and stabilize employment. However, the rise of neoliberalism has reversed many of these advances, exacerbating health disparities and increasing the burden of poverty-related diseases among disadvantaged groups.

◆ *Collective societal action*

Robert Beaglehole and Ruth Bonita (2010), the experts on global health argue that effective public health requires education, female autonomy, adequate nutrition, and accessible preventive health services, all of which are threatened by neoliberal policies. Epidemiology's origins lie in identifying single causes of infectious diseases like cholera, but the complexity of modern diseases necessitates a focus on multiple causes. This shift, however, has diluted epidemiology's ability to predict and control diseases or inform policy.

◆ *Clinical epidemiology*

Contemporary clinical epidemiology has moved away from its social roots, focusing instead on individual behavior and statistical methods. This approach limits its capacity to address broader patterns of health and disease. A sociological model, by contrast, emphasizes environmental factors and structural determinants of health. For instance, Durkheim's work on suicide highlighted the importance of social ties, demonstrating how weak or excessively strong integration into society affects mental health. In this tradition, sociologists study how social networks, stress, and community dynamics influence health outcomes.

◆ *Political and cultural institutions*

Peter Davis, a New Zealand public health sociologist (2001), advocates shifting health research and policy from individual diseases to the economic, political, and cultural institutions that shape health. He argues that economic structures, such as labor markets prioritizing profit over safety, contribute to industrial accidents and deaths. The rise of statistical methods since World War II has further shaped epidemiology, emphasizing computational data and positivist approaches. While this has expanded the field's analytical capabilities, it has also sidelined qualitative insights and structural factors, such as social class, in understanding health. This reductionist perspective limits the scope of epidemiology in addressing the root causes of health inequalities.

◆ *Infections and inequalities*

We conclude this unit by citing another interesting study. Paul Farmer, a renowned medical anthropologist and physician, discusses in his book *Infections and Inequalities: The Modern Plagues* (2001) his efforts to combat AIDS in rural Haiti and drug-resistant tuberculosis in the slums of Peru. With over fifteen years of experience as a doctor and anthropologist, Farmer shares his firsthand experiences, showing how these diseases disproportionately impact poor communities. He highlights the "modern inequality" that fuels the spread of diseases such as AIDS, tuberculosis, malaria, typhoid, and newer outbreaks like Ebola and cholera, emphasizing how social and economic factors worsen these health crises. Through his ethnography of medical anthropology, Farmer critiques common public health approaches, arguing that strategies like "cost-effective treatment" and blaming patients for "noncompliance" unfairly place the responsibility for illness on the victims. He asserts that broader social and economic forces, both globally and locally, determine who falls ill and who remains healthy, which highlights the relations between infections and inequalities.

## Summarised Overview

From this unit, you have learned that health is more than just the absence of disease; it includes physical, mental, and social well-being. The biomedical model views health through measurable biological standards, but sociologists and anthropologists argue that cultural beliefs and personal experiences also

shape how people perceive health. Health, illness, and disease are related but distinct concepts. Illness is a personal experience of feeling unwell, while disease is a medical condition diagnosed by professionals. Sickness refers to the social role assigned to someone who is ill, affecting how they are treated in society. Understanding health requires a broad, inclusive perspective that considers medical, social, and cultural factors.

Well-being goes beyond health—it includes happiness, economic stability, and social connections. Historically linked to the idea of welfare, well-being today is measured both objectively (using data like income and life expectancy) and subjectively (through personal satisfaction and mental well-being). Since well-being is influenced by economic and social conditions, it varies across different societies. Theories such as Self-Determination Theory and the Theory of Human Need highlight the importance of autonomy, cultural influences, and adaptation in well-being. In simple terms, well-being is about helping people live fulfilling lives by meeting their needs, reducing risks, and fostering social belonging. The Happiness Index evaluates well-being based on income, social support, and life expectancy, contributing to the World Happiness Report. Bhutan's Gross National Happiness (GNH) focuses on sustainable development, governance, and cultural preservation. Meanwhile, Quality of Life (QoL) studies assess how well people live based on health, relationships, and environmental factors. The WHOQOL program and the Physical Quality of Life Index (PQLI) offer global standards for understanding well-being beyond economic growth.

You have also learned about the concepts of disease and social epidemiology. Historically, scientists like Pasteur and Koch shaped our understanding of disease through the doctrine of specific etiology, which links illnesses to microorganisms. However, modern health issues often have multiple causes, including genetics, social conditions, and individual behaviors. Over time, epidemiology has shifted from a public health approach to an individualistic model, where state intervention in health has decreased due to neoliberal policies. Sociologists argue that health is not just about personal choices but is shaped by economic, political, and cultural factors. Paul Farmer, for instance, criticizes public health systems for overlooking how poverty and inequality contribute to disease, especially in marginalized communities. Addressing health and well-being requires a holistic approach that considers both medical and social dimensions.

## Self-Assessment Questions

1. What does WHOQOL stand for, and what is its significance in measuring quality of life?
2. Expand PQLI and explain its role in assessing societal well-being.
3. Define health according to the World Health Organization (WHO) and explain its multidimensional nature.
4. What is disease, and how does it differ from illness and sickness?
5. How do health and well-being differ? Provide examples to illustrate your answer.
6. Critically evaluate the limitations of clinical epidemiology in understanding modern health issues.
7. Discuss the concept of the Happiness Index with examples. How does it measure well-being across different nations?
8. Analyze the role of sociology in studying health and well-being. How do social factors influence health outcomes?

## Assignments

1. Critically analyze the biomedical model of health and its limitations in understanding health as a multidimensional concept. How do sociological and anthropological perspectives offer a broader understanding?
2. Discuss the interrelationship between health, illness, and disease. How do cultural and social factors influence their definitions and experiences across different societies?
3. Examine the role of economic, social, and political contexts in shaping well-being. How do objective and subjective aspects contribute to a holistic understanding of well-being?
4. Evaluate the significance of alternative well-being indicators such as the Happiness Index and Gross National Happiness (GNH). How do these measures challenge traditional economic indicators like GDP in assessing societal progress?
5. Analyze the shift in epidemiology from a collective public health approach to an individualistic model under neoliberal policies. What are the sociological critiques of this transition, and how do economic and political inequalities impact public health?



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## Suggested Reading

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## Space for Learner Engagement for Objective Questions

Learners are encouraged to develop objective questions based on the content in the paragraph as a sign of their comprehension of the content. The Learners may reflect on the recap bullets and relate their understanding with the narrative in order to frame objective questions from the given text. The University expects that 1 - 2 questions are developed for each paragraph. The space given below can be used for listing the questions.

SGOU





## Determinants and Dimensions of Health

### Learning Outcomes

Upon reading this unit, the learner will be able to:

- ◆ comprehend the different dimensions of health
- ◆ identify the various determinants of health
- ◆ analyze the importance of social determinance of health

### Background

Health is influenced by a variety of factors, collectively known as the determinants of health. These include personal, social, economic, and environmental elements that shape the well-being of individuals and communities. For example, where people live, the condition of their surroundings, their genetic makeup, their level of education, their type of work, and the quality of their social and interpersonal relationships all play a role in determining health outcomes. However, many of these factors are beyond an individual's direct control. For instance, people cannot always choose where they live, the state of their environment, or the genetic traits they inherit. Similarly, access to quality education and stable jobs is often influenced by larger social and economic systems. These external determinants create a context in which people live and make decisions about their health.

Health promotion, therefore, aims to address these diverse factors to improve overall well-being. On one hand, it targets those aspects of health that individuals cannot control, such as reducing environmental hazards like pollution or ensuring access to clean water and safe housing. On the other hand, it encourages individuals to take actions within their control, such as adopting healthier behaviors. These include quitting smoking, eating a balanced diet, exercising regularly, and managing stress. By addressing both external factors and personal choices, health promotion seeks to create an environment where individuals and communities have the opportunity to lead healthier lives. This comprehensive approach acknowledges that health is not just an individual responsibility but is shaped by the broader social and physical context in which people live. This unit will shed light on these issues.



## Keywords

Social health, Environment, Well-being, Illness, Rio declaration

## Discussion

◆ *Change and challenges*

### 1.2.1 Physical Determinants of Health

Physical determinants of health refer to the aspects of the environment that affect an individual's health, including both the natural and built environments, as well as exposure to harmful substances. These factors can either promote well-being or contribute to health challenges.

The key physical determinants of health include:

1. **Natural Environment:** Elements of the natural environment, such as climate, weather, and plants, have a direct impact on health. For instance, extreme weather conditions can exacerbate health problems, while a clean and safe natural environment can promote health and well-being.
2. **Built Environment:** The design and safety of physical spaces, including buildings, transportation systems, workplaces, schools, and homes, play a significant role in health outcomes. Safe, accessible, and well-maintained environments are critical for preventing injury and supporting good health.
3. **Harmful Substances:** Exposure to harmful substances, such as air pollution, toxic waste, or hazardous chemicals, can lead to a range of health problems, including respiratory issues, cancers, and neurological disorders. Proximity to toxic sites is a key focus in environmental health research.
4. **Access to Health-Related Resources:** The availability and accessibility of resources such as healthy foods, recreational opportunities, medical care, and clean water directly affect health. A lack of access to these resources can lead to poor health outcomes and increased health inequities.

◆ *Social factors*

### 1.2.1.1 Social Determinants of Health

Social determinants of health refer to the conditions in which people are born, grow, live, work, and age, which influence health outcomes. These factors are crucial in understanding health inequities, as they reveal the unjust and preventable differences in health status within and between countries. Health outcomes tend to follow a social gradient, where individuals in lower socioeconomic positions experience poorer health compared to those in higher positions, regardless of national income levels.

The key social determinants of health include:

1. **Income and Social Protection:** The financial resources and safety nets available to individuals significantly impact their ability to access health care, nutrition, and other essentials.
2. **Education:** Higher levels of education are associated with better health outcomes, as educated individuals are more likely to engage in healthy behaviors and have access to resources that promote well-being.
3. **Unemployment and Job Insecurity:** Employment status is a major determinant of health, with unemployment and job insecurity contributing to stress, reduced access to healthcare, and unhealthy lifestyles.
4. **Working Life Conditions:** The quality and safety of the work environment influence both physical and mental health. Poor working conditions can lead to injuries, stress, and long-term health issues.
5. **Food Insecurity:** Lack of access to adequate, nutritious food is a critical determinant of health, affecting physical growth, development, and chronic disease risk.
6. **Housing, Basic Amenities, and the Environment:** Safe, affordable housing, access to clean water, sanitation, and a clean environment are fundamental to health. Poor living conditions can lead to respiratory diseases, infections, and other health problems.
7. **Early Childhood Development:** Early life experiences, including nutrition, caregiving, and stimulation, have lasting effects on physical and mental health across the lifespan.

8. **Social Inclusion and Non-Discrimination:** A society that promotes social inclusion and reduces discrimination contributes to better mental and physical health outcomes for marginalized groups.
9. **Structural Conflict:** Social conflicts, whether political, economic, or racial, can negatively impact health by disrupting communities and limiting access to resources.
10. **Access to Affordable Health Services:** Affordable, quality health services are essential to address health needs and promote equity. These social factors play a significant role in shaping an individual's health and well-being, either positively or negatively influencing their overall health status and contributing to disparities in health outcomes. We may note that Health insurance is not equally available, as the rich and formal sector employees have access to schemes, while the poor and unorganized sector workers are left out.

In 2003, the World Health Organization (WHO) suggested that the social determinants of health included:

- i. Social gradients (life expectancy is shorter, and disease is more common further down the social ladder)
- ii. Stress (including stress in the workplace)
- iii. Early childhood development
- iv. Social exclusion
- v. Unemployment
- vi. Social support networks
- vii. Addiction
- viii. Availability of healthy food
- ix. Availability of healthy transportation.

◆ *Clinical practices*

More specifically, Farmer et al. (2006) state that “Biosocial understandings of medical phenomena [such as the social determinants of health] are urgently needed”. Paul Farmer’s view is that modern medicine is focused at the molecular level, and there is a “gap” between social analysis and everyday clinical practices.

The WHO later developed a Commission on Social Determinants of Health, which in 2008 published a report



◆ *Commission on social determinants*

entitled “Closing the Gap in a Generation”. This report identified two broad areas of social determinants of health that needed to be addressed. The first area was daily living conditions, which included healthy physical environments, fair employment and decent work, social protection across the lifespan, and access to health care. The second major area was the distribution of power, money, and resources, including equity in health programs, public financing of action on the social determinants, economic inequalities, resource depletion, healthy working conditions, gender equity, political empowerment, and a balance of power and prosperity of nations.

◆ *Rio Political Declaration*

The 2011 World Conference on Social Determinants of Health brought together delegations from 125 member states and resulted in the *Rio Political Declaration on Social Determinants of Health*. The Rio Political Declaration on Social Determinants of Health was adopted on October 21, 2011, at the World Conference on Social Determinants of Health. It showed a global commitment to using social factors to reduce health inequalities and achieve important global goals. The declaration encouraged countries to create national action plans and strategies to improve health for everyone. This declaration involved an affirmation that health inequities are unacceptable. It noted that these inequities arise from the societal conditions in which people are born, grow, live, work, and age, including early childhood development, education, economic status, employment and decent work, housing environment, and effective prevention and treatment of health problems.

◆ *Access to care and resources*

The United States Centers for Disease Control defines social determinants of health as “life-enhancing resources, such as food supply, housing, economic and social relationships, transportation, education, and health care, whose distribution across populations effectively determines length and quality of life”. These include access to care and resources such as food, insurance coverage, income, housing, and transportation. Social determinants of health influence health - promoting behaviors, and health equity among the population is not possible without equitable distribution of social determinants among groups. Woolf states, “The degree to which social conditions affect health is illustrated by the association between education and mortality rates”.

Marmot and Bell found that in wealthy countries, income and mortality are correlated as a marker of relative position

◆ *Income inequality*

within society. This relative position is related to social conditions that are important for health, including good early childhood development, access to good quality education, rewarding work with some degree of autonomy, decent housing, and a clean and safe living environment. The social condition of autonomy, control, and empowerment are important influences on health and disease, and individuals who lack social participation and control over their lives are at a greater risk for heart disease and mental illness.

### 1.2.2 Dimensions of Health

◆ *Multi dimensional*

The World Health Organization (WHO) defines health as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.” This definition tells that there are many paths to wellness, such as spiritual, environmental, emotional and physical health. Ensuring that all aspects of one’s health are functioning well will help us develop a better sense of overall wellness. While many people associate their wellness with their physical health, it can also be used to describe our environmental, mental, intellectual, occupational, emotional or spiritual well-being. These different dimensions of health interact together to help determine one’s full quality of life. The following are the major dimensions of health:

#### 1. Physical Health

Physical health refers to the proper functioning of the human body and its ability to perform daily activities efficiently without illness or injury. It includes aspects such as:

- ◆ **Structure and Function:** The body’s ability to operate properly, enabling individuals to carry out tasks like walking, eating, and working.
- ◆ **Fitness and Recovery:** Maintaining a healthy body weight, staying fit through moderate physical activity, and the body’s capacity to recover from illness or injury.
- ◆ **Preventive Care:** Adopting habits like regular exercise, proper nutrition, and getting preventive health screenings to minimize health risks.

Physical wellness also positively influences self-control, determination, and self-esteem. A physically healthy person is better equipped to face challenges, maintain energy levels,

and contribute to their community.

## 2. Social Health

Social health involves building and maintaining satisfying relationships with others. Humans are social beings, and the quality of their interactions with family, friends, and the broader community impacts their overall well-being. Key aspects of social health include:

- ◆ **Healthy Relationships:** Relating positively to family, friends, and others in the community.
- ◆ **Social Norms:** Understanding and adhering to acceptable social behaviors, such as waiting in queues or respecting community standards.
- ◆ **Support Networks:** Developing meaningful relationships that provide emotional and social support during challenging times.

Research has shown that social support networks protect against disease and improve survival rates. Social health fosters harmony within communities and promotes behaviors that contribute to collective well-being.

## 3. Mental and Emotional Health

This dimension of health focuses on an awareness and acceptance of feelings and stressors. Emotional well-being includes the ability to manage your feelings and related behaviors, the ability to cope effectively with stress, and the adaptability to change. There are practical ways to enhance mood, build resilience and improve your response to life's challenges. Just as it requires effort to develop or maintain physical health, the same is necessary for emotional health. Emotions contribute to almost all aspects of our lives, at times, even setting the course of actions. Symptoms of emotional problems, such as hopelessness, depression, anxiety, and even suicidal tendencies, are not always easily detectable but can lead to dire consequences. Awareness and acceptance of our strengths and shortcomings are essential for our emotional well-being.

◆ *Emotional wellbeing*

Mental and emotional health focuses on the psychological and emotional aspects of well-being. It includes:

- ◆ **Emotional Resilience:** The ability to cope with stress, adapt to change, and recover from life's setbacks.

- ◆ **Mental Clarity:** Maintaining cognitive abilities like memory, concentration, and decision-making.
- ◆ **Positive Attitude:** Fostering optimism, self-confidence, and emotional stability.

Emotional health plays a critical role in overall wellness, as individuals with strong mental health can better manage stress, build positive relationships, and contribute meaningfully to society.

#### 4. Environmental Health

Environmental health refers to how the external physical surroundings influence well-being. A clean and safe environment is essential for maintaining good health. Key factors include:

- ◆ **Healthy Living Spaces:** Access to clean water, proper sanitation, and pollution-free air.
- ◆ **Sustainable Practices:** Protecting natural resources and adopting eco-friendly behaviors.
- ◆ **Community and Workplace Safety:** Ensuring that homes, workplaces, and public spaces are free from hazards.

A healthy environment supports physical, mental, and social health by reducing exposure to harmful conditions and promoting a better quality of life.

#### 5. Vocational Health

The vocational dimension of health pertains to the relationship between an individual's career and overall well-being. For most people, their job constitutes a significant aspect of their lives, and deriving satisfaction from one's work is an integral component of holistic health. Beyond serving as a source of income, an ideal job facilitates personal growth and enables individuals to achieve self-actualization. However, transitions such as retirement often pose challenges, with many retirees struggling to adjust to a life without work. This difficulty, often expressed as a lack of purpose or direction, underscores the critical role of vocational health in overall well-being.

A notable perspective on this issue comes from Abraham Maslow's 1943 theory of the *hierarchy of needs*. Maslow

- ◆ *Job satisfaction*



◆ *Need Hierarchy*

distinguished between deficiency needs—essential for physical and psychological survival, such as physiological needs, safety, love, and belonging—and growth needs, which drive personal fulfillment, including self-esteem and self-actualization. This framework, central to Maslow’s theory of motivation, illustrates how workplace structures can significantly influence the health and well-being of employees. Achieving vocational health involves both individual and systemic efforts. Individuals typically explore various career paths before committing to one that aligns with their aspirations and values. Employers play a pivotal role by fostering opportunities for professional growth, ensuring work-life balance, and creating supportive workplace environments. Additionally, state policies are crucial in safeguarding healthy work conditions and promoting vocational well-being at both individual and societal levels.

## 6. Other Dimensions of Health

Beyond these four major dimensions, health can also be viewed through other lenses:

- ◆ **Spiritual Health:** Connecting with a sense of purpose, values, and beliefs that provide meaning to life. Spiritual wellness involves discovering a set of beliefs and values that bring purpose to your life. While different groups and individuals have a variety of beliefs regarding spiritualism, the general search for meaning for our existence is considered essential to creating harmony with yourself and others regardless of the path to spirituality you choose to follow. It is considered healthier to find your own path to the meaning of life that allows you to be tolerant of the beliefs of others and life that are consistent with your beliefs.
- ◆ **Intellectual Health:** Engaging in lifelong learning, creativity, and critical thinking.
- ◆ **Occupational Health:** Finding balance and satisfaction in professional life while maintaining work-life harmony.

The various dimensions of health are interconnected and influence one another. For instance, poor physical health can lead to emotional distress, while a lack of social support can negatively affect mental health. Addressing all these dimensions ensures a holistic approach to well-

◆ *Interconnection*

being. Similarly, a change in one dimension affects the other dimensions. For example, a person who begins an exercise program to lose weight (physical) may also improve their self-esteem (emotional). A college student studying philosophy to fulfill university requirements (intellectual) may discover meaning in life and a purpose for living (spiritual). When someone is ill (physically), he probably doesn't feel like spending time with his friends (social).

◆ *Relationships*

**1.2.2.1 Significance of the Social Dimension**

Building and maintaining satisfying relationships comes naturally to us as we are social animals. Being socially accepted is also connected to our emotional well-being. The ability to make and maintain healthy relationships with other people, e.g. being able to relate to parents, friends, and teachers in a way that your community finds acceptable, is important. It also includes accepting social standards/norms of behavior, for instance, waiting in queues and behaving appropriately at the cinema. This dimension of health focuses on the process of creating and maintaining healthy relationships that provide support, such as from friends and family.

◆ *Role of social support*

A joint Yale University/University of Utah research study states, "The strongest evidence that social support is related to health or disease comes from studies of large populations demonstrating that social support or social networks are protective against all-cause mortality. It also appears that social support is negatively associated with cardiovascular death and that it protects against recurrent events and death among persons diagnosed with disease." Making time for positive experiences with friends and family can build emotional reserves and strengthen social connections in times of need. Social wellness is the ability to interact with people, respect yourself and others, develop meaningful relationships and develop quality communication skills. This allows you to establish a support system of family and friends.

Those with high social wellness believe that it is important to:

- a. Live in harmony with the environment and others.
- b. Consider the common welfare of the community over their own.
- c. Develop interdependent healthy relationships while developing healthy behavior.

- d. Create a balance between their community and the environment.

◆ *Communication with relationships*

The social dimension of health is made up of the cultural and social aspects of the relationship between patients and health professionals. This relationship is a social negotiation affected by beliefs, practices, interests, and power dynamics. Communication within this relationship can have a powerful impact on health outcomes. The influence of this relationship upon health is not limited to Western, allopathic, and biomedical systems but is equally as important in other medical systems throughout the world. The stark fact is that most diseases on the planet are attributable to the social conditions in which people live and work. The socially disadvantaged have less access to health services and get sicker and die earlier than the privileged. Despite impressive technological advances in medicine, global health inequalities are worsening. There is no single definition of the social determinants of health. Still, there are commonalities, and many governmental and non-governmental organizations recognize that there are social factors which impact the health of individuals.

## Summarised Overview

From this unit, you have learned about the determinants and dimensions of health. Physical determinants of health refer to environmental factors that influence an individual's well-being. These include the natural environment, such as climate and weather conditions, which can impact health positively or negatively. The built environment, encompassing infrastructure like housing, transportation, and workplaces, affects safety and accessibility. Additionally, exposure to harmful substances such as air pollution and toxic chemicals can cause serious health issues. Access to essential resources like clean water, nutritious food, and medical care also plays a crucial role in determining health outcomes. Social determinants of health focus on the societal conditions that shape health experiences, including economic status, education, employment, and housing. Income levels and job security influence access to healthcare, nutritious food, and stable living conditions. Social inclusion, education, and childhood development impact long-term well-being, while discrimination and structural conflicts create disparities in health outcomes.

You have learned that health is a multidimensional concept encompassing physical, mental, and social well-being. Physical health refers to the body's ability to function optimally, supported by exercise, nutrition, and preventive care.

Social health involves meaningful relationships and community interactions, which provide emotional support and stability. Mental and emotional health encompasses psychological resilience, stress management, and self-awareness. These dimensions interact to shape overall wellness, demonstrating that health is more than the absence of disease – it is a holistic state of well-being.

## Self-Assessment Questions

1. In which year was the Rio declaration adopted?
2. What is meant by occupational health?
3. What are the differences between social and mental health?
4. List the key physical and social determinants of health as identified by the WHO.
5. Explain how the built environment influences health outcomes in both urban and rural settings.
6. Analyze how food insecurity can impact physical, mental, and social health in disadvantaged communities.
7. Compare and contrast the role of income and education as social determinants of health.

## Assignments

1. Explain the global response to social determinants of health with reference to WHO initiatives such as the *Closing the Gap in a Generation* report and the Rio Political Declaration.
2. Design a policy framework to improve access to healthcare and healthy living conditions for marginalized populations.
3. Examine a real-life case study where environmental pollution has led to significant public health concerns.
4. Debate the statement: “Health inequities are primarily a result of social rather than biological factors.”



5. Critically analyze the impact of social determinants of health on health inequities. How do income, education, and employment influence health outcomes across different populations?
6. Evaluate Paul Farmer's argument on the limitations of modern medicine in addressing social determinants of health. How does a biosocial approach enhance our understanding of public health?

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## Suggested Reading

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## Space for Learner Engagement for Objective Questions

Learners are encouraged to develop objective questions based on the content in the paragraph as a sign of their comprehension of the content. The Learners may reflect on the recap bullets and relate their understanding with the narrative in order to frame objective questions from the given text. The University expects that 1 - 2 questions are developed for each paragraph. The space given below can be used for listing the questions.

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## Social Basis of Health

### Learning Outcomes

Upon reading this unit, the learner will be able to:

- ◆ define key concepts related to social class, gender, ethnicity, culture and their influence on health
- ◆ explain how social class affects health outcomes and access to healthcare
- ◆ describe the impact of gender roles and expectations on health behavior and well-being
- ◆ discuss how ethnicity and cultural beliefs shape health perceptions and practices

### Background

From the previous units, you have understood that health is not merely a biological phenomenon but a deeply social issue influenced by various structural factors. Sociologists examine how social class, gender, ethnicity, and culture shape health outcomes and access to healthcare. Social class determines the availability of resources such as nutritious food, safe housing, and quality medical care, which significantly impact health. Lower-income groups often experience higher rates of illness and lower life expectancy due to poor living conditions and limited healthcare access. Similarly, gender plays a crucial role in health experiences, as societal norms and expectations influence health behaviors, exposure to risks, and access to medical services. Women, for instance, may face gender-based discrimination in healthcare, while men may be discouraged from seeking medical help due to cultural ideals of masculinity. Ethnicity and culture also significantly shape health outcomes by influencing lifestyle practices, health beliefs, and medical treatments. Cultural perceptions of illness, traditional healing practices, and trust in formal healthcare institutions vary across communities. Ethnic minorities often experience disparities in healthcare due to discrimination, language barriers, and systemic inequalities.



The relationship between health and development is another key focus in sociology. Health is both a driver and an outcome of development, as improved healthcare systems contribute to economic growth, and socio-economic advancements lead to better health indicators. However, in many developing countries, rapid urbanization, environmental degradation, and economic inequality create new health challenges, including the spread of infectious diseases and the rise of non-communicable diseases. Addressing these issues requires a multidisciplinary approach, integrating social policies, public health strategies, and community participation to ensure equitable and sustainable health development. A sociological perspective on health helps in understanding these complex interconnections and formulating effective interventions to reduce health inequalities.

## Keywords

Black report, Medicalisation, Medical construction, Aboriginality, Cultural variations

## Discussion

### 1.3.1 Social Class and Health

#### ◆ Inequalities

Class inequalities in health are a significant area of study. Here, “inequalities” do not simply refer to natural variations among individuals—differences in health and strength are inherent to the human condition. Rather, these inequalities are socially patterned and often seen as unfair or avoidable. This concern is not new. Over a century ago, early public health advocates identified social and physical environments as key drivers of the unequal distribution of disease and mortality. In the 1970s, inequality in health resurfaced as a public issue, culminating in the publication of the *Black Report* in 1980.

The *Black Report* and subsequent research proposed several explanations for the link between social class and health:

1. **Structural Factors:** Poorer working and living conditions among lower occupational classes expose individuals to greater health risks. Poverty can lead to inadequate diets or substandard housing, both of which harm health.



**2. Behavioral and Cultural Factors:** Health-related behaviors, such as smoking or unhealthy diets, are more common among less-educated and lower-income groups. Cultural factors, including a lack of “future orientation” or a diminished sense of control over health, may also contribute.

**3. Psychosocial Stress:** Stress from social and economic disadvantages may indirectly affect health.

◆ *Difference in life expectancy*

There is a significant difference in life expectancy depending on the social class to which a person belongs. Generally speaking, individuals from manual or working-class backgrounds are more likely to die younger, age faster, and experience more long-term limiting illnesses than those from non-manual or middle-class backgrounds.

◆ *Black report*

Going back to the mid-1800s, Marx’s collaborator Engels wrote about the poor health of the working class in Manchester. He claimed that the high levels of disease, illness, and death among the working class constituted a form of “social murder” committed by the bourgeoisie. Landmark reports such as the *Black Report* (1980) and the *Acheson Report* (1998) strongly indicated that social class affects health outcomes. Two perspectives attempt to explain the existence of class and health inequalities: the psychosocial perspective and the neo-material perspective that we discuss below.

#### **a. Psychosocial Perspective**

◆ *Emotional experiences*

The psychosocial perspective emphasizes the negative emotional experiences of living in an unequal society, particularly feelings of stress and powerlessness. Wilkinson’s (1996) model argues that the greater the inequality in a given society, the less social cohesion it has, resulting in increased insecurity and isolation among disadvantaged groups. This insecurity and isolation lead to chronic stress, which adversely affects the body by moving through biological pathways, particularly the nervous system, causing various health issues.

#### **b. Neo-Material Perspective**

The neo-material perspective focuses on the unequal distribution of resources such as housing, income, and access to education. Marx described the appalling social conditions faced by the poor in large industrial cities, linking morbidity and mortality among slum dwellers, factory

◆ *Unequal distribution of resources*

workers, and the unemployed to these conditions. Similarly, Engels argued that illness could not be understood solely through biology and pathology but must also be attributed to social structures, particularly those shaped by capitalism. For example, a study in Mumbai in the late 1990s reported the eviction of 167,000 people due to slum clearance for commercial and residential developments. Children of these displaced families experienced nutritional deprivation, diarrhea, respiratory diseases, and skin infections due to their unstable living conditions and the financial strain on their families.

### 1.3.1.1 Class Inequalities and Health

◆ *Social selection perspective*

The relationship between socioeconomic inequalities and health disparities is evident in life expectancy figures. Those at the bottom of the socio-economic hierarchy die younger than those at the top, and children born into low-income families face a significantly higher risk of death before the age of five. The social selection perspective suggests that the lower classes, characterized by limited employment opportunities, education, and material resources, contain most of the unhealthy individuals in society. Conversely, those with better physical and mental health tend to maintain their social superiority.

◆ *Structural conditions*

Sir Michael Marmot, a professor of Epidemiology and Public Health, highlights how structural conditions, such as education, job nature, housing, access to nutritious food, and quality healthcare, determine health outcomes. Social reformers of the 19th century, such as Booth, Henry Mayhew, and Engels, linked poverty and inequality to disease and death, arguing that the pursuit of profit under capitalism perpetuates illness and that individuals are powerless to protect themselves in such a system. He demonstrated that occupational status is a robust predictor of life-threatening conditions. Work-based psychosocial factors, such as autonomy, variety, monotony, and job direction, are critical determinants of health. The *Whitehall Study*, a classical longitudinal study, established a clear relationship between social hierarchy and morbidity and mortality. Evidence from this study suggests that relative deprivation, rather than absolute deprivation, is a significant determinant of health outcomes.

Materialist or structuralist explanations of disease emphasize the social, political, and economic factors beyond individual control that adversely affect health. These factors

◆ *Conditions and contexts*

include urban planning, industrial hazards, occupational risks, and social isolation caused by inadequate transportation and healthcare access. For instance, work environments involving repetitive, monotonous tasks or exposure to toxic chemicals increase the risk of illness and premature death. Studies have shown that occupational exposure to hazardous substances, such as asbestos, accounts for 20% of cancer deaths globally.

◆ *Income and health risk*

Income levels also influence diet and housing conditions, which have a direct impact on health. Blane et al. (1997) estimated that diet is responsible for 15% of deaths, with income determining access to a range of nutritious foods. Poor housing and overcrowding are linked to accidents, chronic respiratory diseases, and other health issues. For instance, atmospheric pollution disproportionately affects low-income communities living near industrial zones, as seen in the elevated blood lead levels among African-American children in inner-city slums. Studies like Banerjee et al. (2012) reveal that acute air pollution in Delhi significantly impacts health, particularly causing respiratory issues like pneumonia, bronchitis, asthma, and COPD. Common symptoms reported include cough, chest tightness, allergic rhinitis, sinusitis, headache, dizziness, and eye irritation. It also increases the risk of cardiovascular events and hypertension. However, the severity of health effects may vary depending on individual vulnerability and population characteristics.

◆ *Case studies*

In the 1990s, Russia experienced a significant decline in life expectancy due to increasing mortality from cardiovascular diseases, respiratory illnesses, cancer, and accidents. Between 1991 and 1994, life expectancy for Russian men fell from 63.5 to 57.3 years, and for women, from 74.3 to 71.1 years. Similarly, in the USA, growing income inequality has widened socio-economic health disparities, with poverty-related deaths disproportionately affecting black men and women. In capitalist societies, the pursuit of profit often leads to increased working hours, reduced wages, and insufficient health protections, all of which negatively impact health. Bauman (1992) argued that class is now based on consumption rather than production, giving rise to new patterns of inequality.

### 1.3.2 Gender and Health

Gender refers to social, cultural and psychological differences between men and women. It is the socially

◆ *Definition*

constructed differences in roles and responsibilities assigned to men and women in a given culture or location and the social structure that supports them. Gender roles and expectations are learnt. They can change over time, and they vary within and between cultures. The study of gender and health has recently undergone a period of change and transition. How being a woman or a man affects one's health is currently being developed in a new and interesting way. Some studies indicate that men experience higher levels of early mortality, while women live longer but experience higher levels of morbidity during their lives. The reasons for these differences were often explained by reference to paid and unpaid domestic work roles as well as the wider and often stereotypical social roles that men and women held.

### 1.3.2.1 Women and Health

◆ *Gender and life expectancy*

Another long-standing perception, when looking at gender and health, is that women have some form of biological advantage in terms of life expectancy. In the UK, for instance, a woman born in 2004 can expect to live until she is 81.1 years old, while a male born in the same year can expect to reach the age of 76.7 years (ONS 2006). Such statistics strongly suggest that women do enjoy some form of biological advantage over men. However, the sizable life expectancy advantage that women experience in the UK is very much a Western phenomenon. Overall, women have longer lives than men in most countries, but this is extremely variable. On one hand, in some countries, such as Malawi, the life expectancy for both men and women is very low, while in Algeria there is a negligible difference in life expectancy for women and men. The reasons for this are multiple and diverse. For example, it depends on the levels of health care a country can offer, where childbirth is safer, and the levels of poverty and endemic illness, such as in Malawi, which faces widespread poverty and has many people infected with HIV/AIDS.

### 1.3.2.2 Medicalisation of Female Body

Sociologists argue that there are more women patients because of their social role, and because of the medicalization of their life cycle. It is not because they are biologically sicker than men. They argue there is a process of medicalization which shows how the patriarchal medical construction of women as inferior to men, and specifically of the use of medical technology to subordinate women. Feminists argue that medicine plays a vital role in enforcing conformity to social roles and is especially targeted at women. It reinforces

◆ *Patriarchal constructions*

passivity, submission, and dependence as appropriate feminine virtues. This is because controlling women's ability to reproduce is central to a patriarchal society. They argue almost all the medical attention paid to women is around their reproductive organs and their life cycle as it relates to their ability to have children. Dr. Arathi PM has studied the medicalization of the female body in infertility research. Marxist-feminists have argued that the origins of capitalism, patriarchy and medicine are intertwined. The need to guarantee the legitimacy of offspring to allow for the inheritance of capital meant that the medical profession played a crucial role in the control of women.

◆ *Labeling of female roles*

By focusing on the individual rather than their social location, doctors reproduce the situations that lead women to the surgery in the first place. Treating depression with drugs reinforces the traditional role of women which they are seeking to escape. In this, the feminists also point to the role of multinational drug companies, who, in their advertising, 'reinforce patriarchal, sexist attitudes, medical authority and patient powerlessness'. Aspects of women's lives surrounding their reproductive capacity have also been medicalized. Menstruation, premenstrual syndrome and menopause provide good examples. Women's illnesses are both a consequence of and a response to a patriarchal society. Feminist sociologists also argued that medicine labels women's resistance to their social roles with a special set of diseases, for example, hysteria, chlorosis, agoraphobia and anorexia nervosa. When defined as medical problems, which can only be resolved with medical solutions, women lose control of fundamental aspects of their experience of fertility, sexuality, menopause and ageing. The female body is extensively medicalized, significantly impacting women's health.

◆ *Hysterectomy*

In the context of Kerala, a hysterectomy refers to a surgical procedure involving the removal of the uterus, commonly performed in hospitals to address various gynecological conditions such as fibroids, heavy menstrual bleeding, uterine prolapse, and certain cancers. As observed in other regions, hysterectomies in Kerala are frequently conducted to manage conditions like fibroids, severe dysmenorrhea, uterine prolapse, or malignancies affecting the reproductive system.

### 1.3.2.3 The Medical Construction of the ‘Inferior’ Female Body

#### ◆ Gender selection

In patriarchal medical frameworks, the female body is often constructed as biologically and functionally inferior to the “standard” male body. Conditions frequently labeled by gynecologists as psychogenic, or resulting from incomplete feminization, include dysmenorrhea, excessive pain during labor, menstrual irregularities, pelvic pain, infertility, recurrent miscarriage or premature delivery, excessive nausea in pregnancy, toxemia of pregnancy, and labor complications. These issues are framed in ways that emphasize women’s reproductive capacities as problematic and pathological, reinforcing the perception of female bodies as inherently flawed. This medical construction perpetuates a cycle of disadvantage. Women’s health risks are compounded by the *feminization of poverty*, which limits their access to resources needed to address health concerns. As a result, women are more likely to be diagnosed with psychosomatic conditions rather than physical ailments, leading to delays in proper treatment. By the time medical intervention occurs, women are often older, sicker, and less likely to benefit from the care provided.

#### ◆ Gender bias

Moreover, research indicates that the doctor-patient relationship is often shaped by the status and gender biases of the medical professional. The higher the status of the doctor, the more unequal and sexist the interaction tends to become, further marginalizing women within healthcare systems. These dynamics illustrate how patriarchal ideologies not only shape medical discourses but also actively contribute to systemic inequities in women’s healthcare.

#### ◆ Medical profession and female role

### 1.3.2.4 Capitalism, Gender, and Health

In contemporary capitalist systems, the medical profession plays a pivotal role in legitimizing women’s domestic roles within the private sphere. By framing women’s mothering and nurturing responsibilities as natural and biological “facts,” medicine reinforces traditional gender roles. This ideological construction ensures the reproduction, rearing, and nurturing of the next generation of workers at minimal cost to capitalists, thereby serving the interests of capital accumulation. Furthermore, the medical profession places a disproportionate share of responsibility on women for the healthcare of economically unproductive sectors of the population, such as children and the elderly. This perpetuates

systemic inequities by assigning women unpaid caregiving roles under the guise of biological predisposition, thus subsidizing capitalist economies without direct costs to employers or the state.

Feminist critiques of the medicalization of women's bodies have highlighted important sociological issues regarding the relationship between gender, health, and power. For example, while recognizing premenstrual syndrome (PMS) as a legitimate medical condition provides women with a socially validated explanation for their stress, it also risks reducing their lived experiences to biological determinism. This framing often leaves women powerless, as male-dominated medical discourses define their bodies and experiences as inherently diseased, further entrenching patriarchal authority within healthcare systems. These critiques underscore the need to challenge the ways in which medicine reinforces gendered inequalities and to reframe women's health issues within broader social and economic contexts.

◆ *Biological determinism*

### 1.3.2.5 Gender and mental health

A consistent conclusion in the sociological literature on mental health and gender is that women exhibit higher rates of certain mental illnesses compared to men. In their comprehensive reviews of women and depression, Bebbington (1996) and Nazroo et al. (1998) highlighted several key findings:

◆ *Mental health*

1. Women report more frequent depressive episodes, ranging from mild to severe, compared to men.
2. Women's heightened vulnerability to depression is strongly linked to their role identities. For instance, women who feel a deep sense of attachment and responsibility for their children are at a significantly greater risk of depression when faced with child-related issues, such as academic difficulties or substance abuse.

One of the most influential studies in this field was conducted by Brown and Harris (1978), which proposed a model explaining women's vulnerability to depression through three key components:

#### 1. Vulnerability Factors

These are life circumstances or events that increase a

woman's susceptibility to depression. Four primary factors were identified:

- ◆ Loss of a mother before the age of 11.
- ◆ Presence of three or more children under the age of 15 at home.
- ◆ Absence of a confiding relationship, particularly with a spouse.
- ◆ Lack of employment, either full-time or part-time.

## 2. Provoking Agents

Certain life events, particularly those involving loss or disappointment, serve as triggers for depressive episodes. Examples include the death of a loved one, job loss, or the discovery of a partner's infidelity.

## 3. Symptom-Formation Factors

Women over 50 years of age and those with low self-esteem are at the greatest risk of developing depression. It is important to note that the higher rates of diagnosed depression in women are not necessarily indicative of greater prevalence but may reflect gender biases in medical practice. Patriarchal medicine is more likely to diagnose women with psychiatric disorders compared to men, often framing women's mental health issues through the lens of biological determinism rather than social context. Medical technologies are frequently and unnecessarily applied to women, from the overprescription of mood-altering drugs to invasive surgical interventions during pregnancy. This medicalization of women's bodies reinforces societal norms that position them as inherently fragile or pathological. Men, on the other hand, are also subject to the demands of a patriarchal society, which shape their health and behavior. Societal expectations for men to "behave like men" often push them into hazardous activities, increasing their risk of accidents, suicide, and other forms of premature mortality. These findings emphasize the need to contextualize mental health within broader sociological frameworks, highlighting how gendered social roles and expectations contribute to differential experiences and diagnoses of mental illness.

- ◆ *Medical technology*

### 1.3.3 Ethnicity and Health

Ethnicity refers to the cultural heritage and identity of a group, which is socially learned and constructed. It can be a



◆ *Concept of ethnicity*

self-chosen category used for empowerment or one imposed on a group as a means of control. In contrast, race is often associated with biological differences based on physical features such as skin color, though genetic variations among humans are minimal. While race is perceived as rooted in biological or genetic traits, ethnicity is entirely a social construct.

◆ *Ill-health among ethnic minorities*

Research on ethnicity and health has consistently highlighted the disproportionate burden of ill-health among ethnic minority groups in the UK. Many individuals from these groups report poor health and long-term limiting illnesses. Early research on South Asians and coronary heart disease (CHD), such as Nazroo (1998) and Gupta et al. (1995), suggested that genetic predisposition, cultural practices like cooking with ghee, lack of exercise, or limited use of medical services might explain these health outcomes.

◆ *Migration and health*

However, works by researchers such as Ahmad (2000), Nazroo (2006), and Smaje (1996) provide a more nuanced understanding of the complex interplay between ethnicity, society, and health. Higginbottom (2006) summarizes that variations in health and illness among ethnic groups result from factors such as migration, cultural adaptation, racism, host community reception, socio-economic conditions, and societal ideologies. Chahal (2004) reviewed research indicating that Black and ethnic minority groups often face challenges in accessing medical and health services, reporting negative experiences, particularly in mental health care. Black individuals are overrepresented in mental illness statistics, more likely to be placed in secure wards, and tend to receive different or poorer care than their White counterparts.

◆ *Tribal health*

In the context of Kerala, renowned for its exemplary health indicators, often comparable to those of developed nations, there are notable disparities within the state's model of "good health at low cost." Among the most marginalized groups are the Scheduled Tribe communities, who experience significant health disadvantages. These communities face a range of health concerns, including malnutrition, anemia, and dermatological conditions, which stem from intersecting factors such as poverty, limited access to healthcare services, and systemic social stratification.

Historical evidence further demonstrates the intersection of ethnicity and health. Studies on Australian Aborigines

◆ *Australian Aborigines*

and African Americans show that ethnicity operates independently of class in influencing the distribution of disease. Between 1932 and 1972, the U.S. Department of Public Health conducted a controversial natural history experiment on syphilis. This study involved 400 poor Black sharecroppers with latent syphilis who were deliberately denied treatment to observe the disease's progression. The men were subjected to invasive medical procedures under the guise of treatment and were compensated with meals and the promise of a dignified burial. This experiment highlights the unethical use of ethnicity in medical research and its enduring impact on health disparities. The study also reflected racially biased perceptions of Black sexuality, assuming that Black men had larger penises than White men, linking this to higher libidos and immoral sexual behavior. Ethnicity, in contrast, refers to the cultural and linguistic traits that groups attribute to themselves, based on a shared origin. Historically, ethnicity is seen as the opposite of the race category, particularly in sociology and social movements.

◆ *Two approaches*

Sociological perspectives on ethnicity can be divided into two main approaches: primordialists and instrumentalists. Primordialists view ethnicity as a fundamental aspect of identity, shaping individuals' orientation to the world and serving as the key to their self-definition. Instrumentalists, however, argue that ethnicity is a political tool used by groups to advance their social, economic, and political interests. This creates a dichotomy between understanding ethnicity as a personal, subjective experience and as a structural feature influenced by socio-economic and racial factors.

A comprehensive sociological concept of ethnicity must incorporate both individual identity and the structured patterns of access to resources it creates. Ethnicity emerges in specific historical contexts, often as a form of dominance, influencing access to economic goods, the labor market, and social status. Membership in an ethnic group can shape life experiences regardless of individual attributes. Ethnicity can empower by providing identity, yet it also limits opportunities by restricting access to social and economic resources. For example, Aboriginal people in Australia face significant health disparities. Life expectancy for Aboriginal men is 14–18 years shorter than for non-Aboriginal men, and for women, it is 16–20 years shorter. Aboriginal children are twice as likely to have low birth weights and face higher infant mortality rates, ranging from two to four times that of

◆ *Ethnicity and access to healthcare*

non-Indigenous babies, depending on the region (Day et al., 1997). The Aboriginal population experiences higher rates of infectious and parasitic diseases, with death rates from these conditions 14.7 times higher for men and 17.6 times higher for women compared to non-Indigenous populations. These disparities highlight how poverty and ethnicity intersect to produce chronic disease and early death, independent of class position, as Weber's analysis of status groups suggests.

◆ *Ethnicity and class*

In other contexts, such as the U.S. labor market, ethnicity interacts with the economic class to produce inequities. Black workers, even with the same educational qualifications as White workers, are often paid less and occupy lower-status positions. Genetic explanations for such disparities rely on biological determinism, suggesting that human actions and health outcomes are dictated by genes. These explanations reduce social issues to biology, diverting attention from socio-economic and political causes of health and disease. The scientific appearance of these arguments often serves to stifle debates on the broader structural factors contributing to inequality and poor health outcomes.

◆ *Ethnicity and IQ*

The debate on the role of genetics in determining human traits, including claims that certain characteristics are unchangeable, has been a persistent theme in twentieth-century scholarship. Psychologists Arthur Jensen (1969) and Hans Eysenck (1971) proposed deterministic views on the genetic basis of intelligence, particularly IQ. Herrnstein and Murray (1994), in *The Bell Curve: Intelligence and Class Structure in American Life*, argued that IQ tests are unbiased against ethnic minorities and that intelligence, as measured by these tests, is objective, scientific, and heritable. They controversially claimed that lower IQ scores among Black populations reflect lower intelligence, which they viewed as largely unchangeable due to its genetic basis.

◆ *Genetic explanations*

Genetic explanations have gained popularity in modern societies as they shift focus away from social causes of diseases and inequality. Such explanations often minimize government responsibility to address social determinants of health and justify inequalities as natural and inevitable. Wertz (1992) referred to this phenomenon as the "geneticizing of society," linking it to eugenics—the idea of controlling reproduction to eliminate undesirable genetic traits. Eugenics gained its most infamous application during World War II through Hitler's efforts to eradicate certain

groups, including Jews, homosexuals, and the disabled, based on genetic claims.

◆ *Disease and ethnic groups*

Similar arguments persist today. Reid and colleagues, in the *Medical Journal of Australia*, controversially suggested that higher rates of uterine cancer among working-class women were due to genetic factors carried in their partners' sperm, further attributing simpler DNA structures in working-class men to their supposed inability to think complex thoughts. Such views ignore the social, political, and economic factors shaping health risks. For instance, diseases with perceived genetic causes often disappear when environmental conditions improve. Changes in disease patterns, such as working-class individuals now suffering from conditions historically linked to the upper class (e.g., strokes, heart attacks, and cancer), highlight the influence of social conditions on health.

◆ *Problem in genetic perspective*

Focusing on genetics diverts attention from the social and economic environment and promotes individualistic explanations for disease. Simultaneously, projects like the Human Genome Project are often driven by financial interests rather than purely humanitarian goals. Examining disease patterns among ethnic groups supports Max Weber's argument that social groups can form independently of economic factors, challenging the Marxist view that class alone predicts health outcomes. Overall, racial and genetic explanations obscure the social foundations of health inequalities.

### 1.3.4 Culture and Health

◆ *Different views on health*

Theories of illness have often been rooted in the concept of imbalances—whether in the body, the person, or social relationships. Traditional healing systems from India, China, and Europe reflect this perspective. For example, Ayurvedic medicine in India is based on the belief that the body contains three fundamental substances—*vata*, *pitha*, *kapha* (spirit, phlegm, and bile)—representing universal divine forces. These are analogous to the Greek theory of “humours,” which attributes health to a balance of blood, yellow bile, black bile, and phlegm, grounded in the four elements of fire, earth, air, and water. Both systems emphasize harmony within the body and its surroundings as essential to health.

Murdock (1980), in his ethnographic study of 139 societies, analyzed cultural explanations of health and illness through natural and supernatural causation. Natural causation

◆ *Ethnographic study*

includes explanations such as infection, stress, organic deterioration, accidents, and human aggression. For instance, the germ theory of illness, central to Western scientific medicine, focuses on infection as the cause of disease.

Conversely, supernatural causation theories, which are not recognized by Western medicine, attribute illness to mystical, animistic, or magical forces. Murdock categorizes these theories as follows:

1. **Mystical causation:** Illness is viewed as the result of an impersonal and automatic consequence of an individual's actions or experiences. For example, the Romans attributed health issues to "fate," while the Thonga associated illness with breaking food or sexual taboos.
2. **Animistic causation:** Illness is attributed to the actions of personalized supernatural beings, such as spirits, ghosts, or gods. For example, some cultures believe in spiritual possession or divine punishment as the cause of illness.
3. **Magical causation:** Illness is believed to result from the covert actions of a malicious individual using magical means, such as casting a spell or invoking the "evil eye," a concept prevalent in Mediterranean cultures.

◆ *Culture and illness*

Malinowski (1944, 1948) contributed significantly to understanding these theories by exploring how individuals seek help for illness and strive to restore balance. In his studies of magic, science, and religion, Malinowski concluded that people's responses to illness are shaped by their cultural and societal contexts. Cultural beliefs and prior experiences help individuals interpret illness and provide them with a sense of control over their condition. Moreover, Malinowski noted that people often use multiple frames of reference—combining traditional, supernatural, and scientific explanations—to make sense of illness and seek treatment.

In the same manner, the book *The Jungle and the Aroma of Meats: An Ecological Theme in Hindu Medicine* by Francis Zimmermann (1987) explores the relationship between traditional Hindu medicine (Ayurveda) and the cultural, religious, and ecological context of ancient India. It examines how Ayurveda classifies animals, plants, and land into two

◆ Zimmermann's study

categories: *jāngala* (dry, fertile lands) and *ānūpa* (marshy, unhealthy lands) and how these classifications influence medical practices and dietary prescriptions. Zimmermann also explores the contradiction in Ayurvedic practice, where meat consumption for medicinal purposes challenges the Hindu ideal of vegetarianism as a mark of purity. The book further delves into the cultural meanings of landscapes, the role of animal and plant substances in medicine, and the connection between the natural environment and human health.

### 1.3.5 Health and Development

◆ Problem of poor health

The COVID-19 pandemic highlighted the vital role of health in development, emphasizing that good health is crucial for social stability and economic growth. It impacts everything from poverty eradication to sustainable development and community prosperity. While health improvements have been made globally, disparities remain, with millions lacking access to basic health services, especially in rural and impoverished areas. Health is both a determinant and outcome of development, influencing economic status, productivity, and quality of life. A healthy population fosters sustained growth and prosperity, while poor health hinders development. Moreover, health policies and systems are central to achieving sustainable development goals, such as reducing mortality and providing affordable healthcare in developing countries. Addressing barriers like inadequate healthcare access, poor infrastructure, and insufficient funding is essential to improving health systems, particularly in countries facing severe human resource shortages. Effective healthcare systems depend on efficient service delivery, resource generation, and equitable access to quality care.

Gro Harlem Brundtland, in her role as Director-General of the WHO, emphasized the centrality of health to development, advocating for increased health sector investment in developing countries. This was backed by a 2001 WHO report linking health investments with economic growth. While viewing health as a means to economic development is strategic, it overlooks the intrinsic value of health. An alternative perspective sees health as both an end in itself and a vital component of development, recognizing its interconnection with education and individual agency. Good health enables individuals to actively participate in the development process and fosters agency, which is crucial for effective health systems and broader societal development.

◆ *Centrality of health*

The Aristotelian and Amartya Sen's capability approaches support this view, focusing on human flourishing and individual freedom. This perspective argues that development should be measured by individuals' capacity to function rather than by economic indicators like GNP. Furthermore, the relationship between health and economic development is bidirectional. While health improves productivity and economic outcomes, economic development also enhances access to health resources. Inequalities, however, can negatively impact health, highlighting the need for integrated strategies addressing both health and economic opportunities.

◆ *Multidimensional poverty*

The focus on agency emphasizes individuals' ability to participate in social, political, and economic decisions. This agency is essential for sustainable health and economic reforms. A participatory approach, where individuals shape their own destinies, is key to successful development, as it fosters ownership and ensures reforms are responsive to the needs of the population. This shows that efforts to promote the concept of multidimensional poverty reflect a broader shift in how international development is understood. Over time, the global approach to development has evolved from focusing solely on economic growth to prioritizing human health and wellbeing. This broader perspective includes ideals such as human development, participation, and freedom. At its most ambitious, the goal of international development is to create conditions where all individuals can achieve health and wellbeing. Development policies and government programs aim to establish these conditions in different societies, as seen in initiatives like the Millennium Development Goals, which represent a modest version of this broader vision.

◆ *Broader focus on human development*

The concept of development has shifted from a purely economic perspective to a broader focus on human development. Thinkers like Gandhi, Dudley Seers, and Mahbub ul Haq have long advocated for this approach. However, it was Nobel laureate Amartya Sen who significantly advanced this idea on the global stage in the late 20th century. Sen argued that using income or material wealth to assess wellbeing or poverty is insufficient, as these are merely tools, not the ultimate goals. He introduced the concepts of "capabilities" and "functionings" to define the true ends of human life – what individuals can and do achieve. Sen emphasized that development should be evaluated based on the freedom people have to live lives they value.

◆ *Nussbaum's and Sen's ideas*

Philosopher Martha Nussbaum extended Sen's ideas by including non-economic dimensions such as imagination, emotions, social connections, and recreation. Similarly, Doyal and Gough (1991) proposed a theory of basic human needs, highlighting health and autonomy as essential for wellbeing. Both approaches advocate for universal lists of capabilities that can adapt to different cultural contexts. Since 1990, the *Human Development Reports* have tracked global progress in meeting these needs, and in 2004, the Human Development and Capability Association was established to further these perspectives.

◆ *Entitlements*

During the 1990s, new frameworks for understanding livelihoods emerged, emphasizing the broader assets and strategies people use beyond traditional economic models. Influenced by Sen's early 1980s work on entitlements and research on vulnerability, these frameworks acknowledged the economic, social, and political dimensions of vulnerability. For instance, Sen's analysis of famines highlighted that food shortages often result from reduced entitlements rather than lack of food supply, broadening the understanding of vulnerability (Sen, 1981).

## Summarised Overview

From this unit, you have learned that class inequalities in health reflect socially structured disparities rather than natural variations, often seen as unjust and avoidable. The Black Report (1980) and later research identified structural, behavioral, and psychosocial factors contributing to these disparities, emphasizing the impact of poverty, working conditions, and stress. Gender also influences health outcomes, with women experiencing higher morbidity but longer life expectancy, partially due to medicalization and patriarchal control over reproductive health. Research on ethnicity and health reveals significant disparities, particularly among ethnic minorities in the UK, where socio-economic factors, migration experiences, racism, and systemic barriers contribute to poor health outcomes. You have also learned that health is both a determinant and an outcome of development, with efficient healthcare systems essential for sustainable progress. Thinkers like Amartya Sen and Martha Nussbaum advocate for a broader human development approach, emphasizing capabilities and agency over mere economic metrics. This shift aligns with evolving development policies, prioritizing wellbeing, participation, and freedom alongside economic growth.

## Self-Assessment Questions

1. Define ethnicity.
2. Define gender.
3. What is meant by 'feminisation of poverty'?
4. What was the Tuskegee Syphilis Study, and how does it illustrate the misuse of ethnicity in medical research?
5. What is meant by the "medicalization of the female body," and how do feminist perspectives critique it?
6. Why relative deprivation is considered a significant determinant of health outcomes?
7. Explain the role of capitalism in perpetuating health disparities, as argued by Marxist theorists.
8. How the concept of development evolved, and what is its relationship with health?

## Assignments

1. How do traditional cultural health beliefs, such as those in Ayurveda and Greek humoral theory, differ from Western biomedical explanations of illness? Prepare a detailed report.
2. Describe the health disparities faced by Scheduled Tribe communities in Kerala and identify the factors contributing to their poor health outcomes.
3. Prepare a report on how social determinants such as racism, socio-economic status, and migration influence health outcomes among ethnic minority groups in the world.
4. Explain how Sen's and Martha Nussbaum's perspectives on health, freedom, and human development offer a multidimensional understanding of wellbeing. How can these perspectives inform contemporary health policies and development initiatives?
5. "Diseases are not merely biologically determined but are socially produced." Discuss this statement with relevant sociological arguments and examples.



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## Suggested Reading

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## Space for Learner Engagement for Objective Questions

Learners are encouraged to develop objective questions based on the content in the paragraph as a sign of their comprehension of the content. The Learners may reflect on the recap bullets and relate their understanding with the narrative in order to frame objective questions from the given text. The University expects that 1 - 2 questions are developed for each paragraph. The space given below can be used for listing the questions.

SGOU

# Theoretical Perspectives

**BLOCK-02**



## Marxian Perspective of Health

### Learning Outcomes

After reading this unit, the learner will be able to:

- ◆ comprehend the Marxist perspective of health
- ◆ analyze the role of medicine in capitalist societies
- ◆ examine the commodification of medicine and health care

### Background

Health and medicine, though often viewed through biological or technical lenses, are deeply embedded in social, political, and economic structures. The Marxist perspective offers a critical framework to understand health as a social product, shaped by the material conditions of life and the class structure of society. According to this view, health outcomes and access to medical care are not simply personal or biological issues but are largely determined by the organization of society under capitalism. The distribution of resources, the nature of labor, and the relations of production all play decisive roles in shaping who stays healthy, who gets sick, and who receives treatment. Marxists emphasize the determining role of economic interests in both producing diseases and shaping the way they are addressed. They argue that in capitalist societies, medicine plays a critical role in maintaining the existing class structure by blaming the victims of diseases - often caused by the capitalists' relentless pursuit of profit - for their own conditions. This perspective raises important questions about the relationship between health, illness, and capitalist social organization. It is this aspect that demands a sociological interrogation that we now turn our attention to.

The first unit of this block critically examines the intersections of capitalism, class, and health through a Marxist perspective, exploring how illness and healthcare are shaped by class struggle and material inequality. It investigates the ideological and institutional roles of medicine in capitalist societies, the structural functions and criticisms of healthcare systems, and the class inequalities within the medical profession. The unit also analyzes the commodification of medicine and healthcare, the influence of profit motives on medical practices and access,



and how ruling class ideology obscures the social roots of illness. Finally, it traces the shift from the welfare state to the neoliberal state. It highlights how this transformation prioritizes privatisation and capital accumulation over public well-being, encouraging students to critically reflect on health inequities and imagine more just alternatives.

## Keywords

Commodification, Capitalism, Profession, Proletariat, Class, Liberalism

## Discussion

### 2.1.1 Medicine in Capitalist Societies: Functions and Criticisms

One of the key arguments put forth by Marxists is that medicine serves as an instrument of social control. The medical profession often individualizes and depoliticizes diseases, effectively deterring collective action against structural inequalities. For instance, access to a “sick certificate” is tightly controlled, reinforcing the notion that illness is a personal issue rather than a systemic one. Furthermore, high-cost, technical “fixes” are prioritized over preventive measures, which, while lucrative for pharmaceutical and healthcare industries, do not necessarily address the root causes of diseases. This profit-oriented approach to healthcare reflects broader capitalist values and perpetuates class inequalities.

- ◆ *Medicine for social control*

#### 2.1.1.1 Class Inequality in the Medical Profession

The structure of the medical profession itself mirrors the class divisions within capitalist societies. Those who become doctors often come from upper-middle-class, privately educated backgrounds, predominantly male, while nurses are typically lower-middle-class women. These patterns not only reproduce existing class and gender inequalities but also shape the culture and practices of the medical profession. Access to healthcare services further reflects these inequalities, with marginalized groups frequently experiencing limited or inadequate care. Interestingly, let

- ◆ *Class division*



us take the study of T.K. Oommen in his book *Doctors and Nurses: A study in Occupational Role Structure* (1978). T.K. Oommen's study highlights the predominance of lower-caste Christian women in the nursing profession, attributing it to four factors: the historical gendered nature of nursing, its perception as ritually 'unclean' by certain communities, its low occupational prestige due to handling male patients, and the socioeconomic background of converts, who found nursing more accessible due to minimal educational requirements and free training opportunities.

### 2.1.1.2 The Relationship between Health and Capitalist Social Organization

◆ *Economic activity*

Marxist explanations of health and illness highlight the connection between economic activity and the definition of diseases. Medicine, as a major social institution, is deeply influenced by the imperatives of capitalism. This perspective is particularly evident in the work of Vicente Navarro, a prominent sociologist and health policy analyst. Navarro's article, "Work, Ideology, and Science: The Case of Medicine" (1980), explores the following key points:

1. **Bourgeois Dominance in Medicine:** How the capitalist class exerts control over scientific and medical practices, shaping them to serve their interests.
2. **Reproduction of Bourgeois Ideology:** How medical knowledge reflects and reinforces the dominant ideology of capitalism.
3. **Class Struggle in Scientific Knowledge:** How the nature of scientific and medical knowledge is influenced by class struggles.

What do you think about the Marxist critique of capitalist medicine? Do you agree with their perspective, or do you see value in the current healthcare system's approach?

### 2.1.1.3 Commodification of Medicine

◆ *Corporate medicine*

Have you ever considered how medicine, once a noble craft, has become a vital cog in the capitalist machine? According to Navarro, the shift from traditional medicine to what he terms "corporate medicine" reflects four defining characteristics of capitalism's influence on healthcare. Let's explore these changes and their broader implications for society.

## 1. Medicine as Corporate Enterprise

Medicine, once centered on individual skills and community service, has transitioned into “corporate medicine.” This shift means that healthcare is no longer just about healing the sick—it has become a structured, profit-driven industry. Large corporations now dominate the sector, controlling everything from hospital management to pharmaceutical production. How did this happen? The specialization and hierarchical nature of modern medicine play a key role. Specialized fields and complex hierarchies create dependency on corporations for training, equipment, and resources. This has made healthcare a tightly controlled market commodity.

## 2. The Rise of the Medical Workforce

Another major change lies in the composition of the medical workforce. Medicine now employs an extensive wage-labor force. From pharmaceutical industry employees to hospital staff, many work not as independent practitioners but as wage laborers under corporate oversight. This growing workforce reflects the industrialization of healthcare. What about doctors? Interestingly, Navarro highlights the *proletarianization* of medical practitioners. Once seen as autonomous professionals, doctors increasingly find their authority undermined by administrative and managerial staff. This loss of independence symbolizes a broader trend in the capitalist organization of healthcare. You can understand this process by watching the Malayalam movie *Appothecary* (2014), which vividly portrays how doctors are controlled by hospital administration within a capitalist healthcare system.



Image Source: Wikipedia



### 3. Medicine as a Profitable Commodity

Medicine has become immensely profitable for two dominant capitalist interests:

1. The finance sector, through private insurance provision.
2. The corporate sector, through the sale of drugs, medical instruments, and related products.

Large corporations enjoy monopolistic control over these markets, directing and exploiting the medical system for maximum profit.

In a capitalist framework, medicine serves four critical economic functions:

1. Accumulating capital for corporate entities.
2. Providing lucrative investment opportunities.
3. Absorbing surplus labor by employing large workforces.
4. Maintaining the labor force through healthcare services, ensuring workers remain productive.

The integration of medicine into the capitalist economy ties it to the medical-industrial-state complex. State agencies and large firms collaborate closely – governments buy drugs, subsidize research, and maintain hospital infrastructures, creating a mutually beneficial relationship.

### 4. The Ideological Role of Medicine

The influence of capitalism extends beyond economics; it shapes societal ideology. Navarro identifies three ideological functions of healthcare in a capitalist society:

1. **Legitimizing the status quo:** Healthcare often frames social problems, such as poverty and inequality, as individual issues, shifting attention away from systemic causes.
2. **Reproducing capitalist production:** The system ensures the health of workers, maintaining the cycle of production.
3. **Reinforcing class structures:** The organization of health workers mirrors capitalist hierarchies, while

consumption patterns in healthcare reinforce economic divides.

◆ *Transformation*

The capitalist transformation of medicine has commodified care, emphasizing profit over well-being. Medicine, as Navarro points out, is no longer just about healing—it is about consumption, accumulation, and the reproduction of capitalist structures. What does this mean for us as individuals and as a society? Should healthcare prioritize profit or people? Engaging with these questions is essential as we understand the intersection of health and capitalism in the modern world.

#### 2.1.1.4 Commodification of Health Care

This refers to the process by which aspects of everyday life, including basic human needs like health care, are turned into products and services to be bought and sold in the market. In essence, activities or resources that were once freely available or shared within communities are now commodified, meaning they are only accessible through monetary transactions. In the realm of health care, this commodification is becoming increasingly evident. A growing number of health care services, from routine checkups to life-saving treatments, are now packaged as marketable commodities. This shift has left individuals with fewer non-market-based resources to rely on, such as community-driven or government-supported health care initiatives. As a result, access to health care is often determined by one's ability to pay, which exacerbates inequalities in society. A critical aspect of this transformation is the combination of medical specialization and the commodification of health care. Specialization refers to the division of medicine into highly specific fields, such as cardiology or oncology, each requiring advanced expertise, technology, and infrastructure. While specialization has undoubtedly improved medical outcomes, it has also fueled the commercialization of health care, as specialized treatments often come with high costs and significant corporate involvement.

◆ *Specialization and commodification*

In India, despite legal regulations such as the Transplantation of Human Organs Act (THOA) of 1994, amended in 2011, which aims to curb organ trading, promote deceased organ donation, and criminalize the commercialization of organs, concerns about commodification and privatisation persist. Studies indicate a rising trend in organ trafficking, particularly the emergence of a “kidney bazaar” (kidney

◆ *Medical-industrial complex*

market). This trend has given rise to what has been termed the “medical-industrial complex,” particularly in the USA. The medical-industrial complex refers to the close relationship between private corporations, such as pharmaceutical companies and medical equipment manufacturers, and the health care system. These corporations invest heavily in health care, aiming to maximize profits by producing drugs, technologies, and services that are marketed and sold to both providers and patients.

◆ *Changing role of the medical profession*

One of the most significant impacts of these transformations in capitalism is the changing role of the medical profession. Historically, doctors were viewed as autonomous professionals dedicated to patient care. However, with the increasing involvement of corporate investors in health care, the medical profession is becoming more integrated into the system of wage labor. Many medical practitioners now work as employees of large health care corporations or hospital chains, rather than as independent providers. This shift has reduced their professional autonomy and placed them under the control of corporate management, which often prioritizes profitability over patient-centered care. You can observe such a profit-oriented approach in the use of medical equipment in private hospitals.

### **2.1.1.5 Ruling Class Ideology and Health Inequality**

◆ *Unequal structure of society*

Marxists argue that health problems are not simply the result of individual weaknesses or frailty but are deeply rooted in the unequal structure of society. They suggest that unhealthy and stressful work environments, often endured by the working class, play a significant role in the prevalence of health issues. These environments are shaped by the demands of capitalist production, where the emphasis on profit frequently overshadows the well-being of workers. Vicente Navarro extends this critique by highlighting the alliance of interests between the ruling classes and the medical profession. According to Navarro, this partnership benefits both groups, albeit for different reasons, and perpetuates the existing conditions of inequality. For the ruling classes, health inequalities serve as a marker of the stark differences in life chances between themselves and the working classes. The disparities in access to health resources, living conditions, and opportunities reflect the entrenched social and economic hierarchies that favor the ruling elite.

◆ *Economic productivity*

The provision of health care, even through systems like the National Health Service (NHS), is seen by Marxists as serving a specific purpose within this unequal structure. While the NHS and similar systems may appear to provide universal health care, their primary function is to maintain the working population at a level sufficient to sustain economic productivity. This involves ensuring that workers can return to work after illness and remain functional contributors to the economy. In this sense, health care under capitalist systems is less about addressing the root causes of ill health and more about preserving the labor force necessary for sustaining the system of production.

◆ *Mutual benefits*

Navarro's analysis underscores the mutual benefits derived by the ruling classes and the medical profession from this arrangement. For the ruling classes, the health care system supports a reasonably healthy workforce while leaving the broader inequalities in place. For the medical profession, this alliance reinforces their professional dominance and control over the delivery of health care. By focusing on treating illness rather than addressing the structural causes of health problems, the medical profession avoids challenging the existing social order. It secures its position of authority within it.

◆ *Broader inequalities*

From a Marxist perspective, health problems cannot be separated from the broader inequalities that characterize capitalist societies. The unhealthy and stressful conditions faced by workers are symptomatic of a system that prioritizes profit over well-being. Furthermore, the alliance between the ruling classes and the medical profession ensures that these inequalities persist, serving the interests of both groups while perpetuating the structural conditions that undermine health and well-being for the majority. Addressing health problems, therefore, requires challenging the social and economic systems that sustain inequality and limit access to meaningful solutions.

### **2.1.2 From Welfare State to Liberal State**

In the mid-twentieth century, the state played a central role in protecting individuals from the uncertainties of the market, particularly in health care. Welfare systems were established to ensure that essential services like health care were accessible to all, regardless of individual circumstances. This era emphasized collective responsibility, where the state acted as a safety net to shield citizens from

◆ *Resurgence of neo-liberalism*

the economic vulnerabilities inherent in capitalist systems. However, the late twentieth and early twenty-first centuries have witnessed a resurgence of liberalism, often referred to as “neoliberalism.” This ideology emphasized individual responsibility and self-reliance, shifting the focus away from the state’s role in ensuring health and well-being. In this context, individuals are increasingly held accountable for their own health outcomes, with a growing emphasis on personal choices, lifestyles, and risk factors as the primary determinants of health.

◆ *Contemporary epidemiology*

This shift is reflected in contemporary epidemiology, which now prioritizes individual behaviors and risk factors in understanding health and disease. Factors such as diet, exercise, smoking, and stress have become the focus of health research and interventions, while structural determinants of health—such as socioeconomic inequality, housing, and working conditions—receive less attention. This individualistic approach aligns with the neoliberal political and economic circumstances, where structural solutions to health problems are often downplayed in favor of personal accountability.

◆ *Economic climate*

The economic climate shaped by neoliberal policies has far-reaching implications for the medical profession, patients, and the state’s role in health care. Structural changes in the political sphere, particularly the transformation of the welfare state, have led to a redefinition of responsibilities. Under the influence of “new right” economic policies, the welfare state has been significantly scaled back. Public funding for health care has been reduced, and many services that were once free or heavily subsidized are now subject to market forces.

◆ *Individual responsibility*

For the medical profession, this transformation represents a direct challenge to one of its traditional power bases: the right to provide free or affordable health services to the public. As health care systems become increasingly privatized or subjected to budgetary constraints, medical professionals face pressures to adapt to market-driven models of care. These models often prioritize efficiency and cost-effectiveness over comprehensive patient care, potentially undermining the profession’s autonomy and ethical commitments. For patients, the emphasis on individual responsibility can be both empowering and burdensome. While some individuals may feel encouraged to take charge of their health, others—particularly those in disadvantaged circumstances—may struggle to meet these expectations. The erosion of the welfare

state exacerbates health inequalities, as access to quality care becomes increasingly dependent on an individual's financial resources.

### 2.1.2.1 Profit Motive and Accumulation of Capital

#### ◆ Private sector

In the context of contemporary society, the state has sought to reduce its direct responsibilities by encouraging private sector involvement. To achieve this, the state provides substantial subsidies to private enterprises, making investments in sectors like health care more appealing to capitalist investors. While there is rhetoric emphasizing the free market, the state continues to play a pivotal role in ensuring the conditions necessary for the accumulation of capital. This creates a paradox where the state, even in its attempts to devolve responsibility, remains central to maintaining the economic framework that supports capitalism.

#### ◆ Theoretical shift

Theoretical frameworks in sociology have also shifted over time, reflecting broader changes in societal and economic structures. Earlier frameworks, such as functionalism and structural Marxism, emphasized the role of overarching social and cultural systems in shaping individual behavior. Thinkers like Althusser and Poulantzas argued that these systems determined much of human action, often portraying individuals as “dupes” who unconsciously followed societal norms and structures. These perspectives highlighted the power of social structures, such as class and institutional systems, in controlling and influencing individual lives. However, more recent sociological perspectives, such as phenomenology and postmodernism, have challenged this view. These theories place greater emphasis on the individual's ability to shape their own life, focusing on personal agency rather than structural constraints. Postmodernist theory, in particular, argues that the rigid social structures of modernity – such as class and, to a lesser extent, gender – are less significant in defining individual experiences and biographies today. This shift aligns with the growing belief that people now have more choices and options to create their own identities and lifestyles.

### 2.1.2.2 Liberalism and Neo-liberalism in Health Policy

Philosophic liberalism emerged in the 18th century and became an important political idea during the 19th century.



◆ *Emergence of neo-liberalism*

Its main belief was that governments should interfere as little as possible in the economy. According to this idea, society would develop through individuals working independently to pursue their own interests, which was thought to create the greatest happiness for the largest number of people. However, this system mainly benefited the capitalist class because it allowed them to make profits without restrictions and exploit workers.

◆ *Great Depression*

The Great Depression of the 1930s exposed the problems of such an uncontrolled market system. It led to the rise of the welfare state, where governments took an active role in protecting people from the negative effects of the market. Economist John Maynard Keynes suggested that governments should manage production and wages to prevent the cycles of extreme economic growth (“boom”) and severe downturns (“bust”) that are common in capitalist economies. From the end of World War II until the late 1970s, many governments around the world followed interventionist policies. They worked to reduce the harmful effects of market forces by protecting workers, ensuring better living conditions, and stabilizing the economy to avoid high unemployment.

◆ *Reducing the role of the state*

However, since the 1980s, pressure from global institutions like the World Bank and the International Monetary Fund has been causing countries to start reducing the role of the state. Many nations, both rich and poor, have cut funding for public healthcare and education. They have also privatized essential services like electricity, water, transportation, and ports, selling them to private companies. This withdrawal of the government from public welfare reflects the ideology expressed by British Prime Minister Margaret Thatcher, who famously said, “Society does not exist, only the individual.”

## Summarised Overview

This unit has provided a critical overview of health and medicine through a Marxist lens, highlighting the deep connections between capitalist social organization and patterns of health and illness. We began by exploring how the Marxist perspective situates health within the framework of class struggle, emphasizing that illness is not simply a biological phenomenon but a social product influenced by material conditions and economic inequalities. Medicine, in capitalist societies, was examined not only as a tool for curing disease but also as an institution that functions ideologically to maintain social order and workforce productivity, often reinforcing the interests of the dominant class.

The unit further examined class inequality within the medical profession, revealing how access to medical education, specialization, and professional power is stratified along class lines. We also analyzed the commodification of medicine and healthcare, showing how capitalist imperatives have turned health into a commodity, subject to market forces and profit motives. This transformation has prioritized treatment over prevention and individual care over collective well-being, leading to growing disparities in health access and outcomes.

A central focus was on how ruling class ideologies shape our understanding of health, often masking the social determinants of illness and placing the burden of responsibility on individuals rather than on structural factors. This ideological framing sustains acceptance of systemic health inequalities. Lastly, we traced the historical shift from the welfare state to the liberal (neoliberal) state, marking a transition from state-supported public health systems to privatized models driven by efficiency and profit. This shift has intensified the commodification of healthcare and deepened the link between capital accumulation and health service provision.

## Self-Assessment Questions

1. Name the act that regulates organ transplantation in India.
2. Who authored the article *“Work, Ideology, and Science: The Case of Medicine”*?
3. What is meant by the proletarianization of medical professionals?
4. Briefly explain the ideological role of medicine in a capitalist society.
5. How does the shift from a welfare state to a liberal state affect healthcare?
6. What are the problems associated with the commodification of medicine and healthcare?
7. Examine the relationship between social class and patterns of disease from a Marxist perspective.
8. Analyze the key features of medicine in a modern capitalist society.

## Assignments

1. Critically examine the Marxist perspective on health and medicine. How does this framework challenge the biomedical model and reveal the structural roots of illness in capitalist societies?



2. Discuss the ideological and functional roles of medicine in capitalist societies. In your analysis, evaluate how medicine serves both as a tool for maintaining social order and as a site of class conflict.
3. Analyze the nature and impact of class inequality within the medical profession. How do patterns of access, professional hierarchy, and specialization reflect broader class structures in society?
4. Explain the processes of commodification of medicine and healthcare in the Indian context.
5. Evaluate the shift from the welfare state to the liberal (neoliberal) state in the context of the healthcare system in India.

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1. Annandale, E. (2001). *The Sociology of Health and Medicine: A Critical Introduction*. Cambridge: Polity Press.
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## Suggested Reading

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SGOU





## Structural – Functional Perspective: The Sick Role

### Learning Outcomes

After reading this unit, the learner will be able to:

- ◆ familiarise themselves with the structural-functional perspective of health
- ◆ analyse the role of medicine in maintaining social order
- ◆ evaluate the limitations of the sick role in analyzing chronic and acute illness

### Background

From the previous unit, you have understood that health and illness are not merely individual experiences but are deeply embedded within the broader social structure. This unit introduces students to the foundational ideas of the structural-functional approach to health, especially Parsons' concept of the *sick role*, which provides a sociological explanation of how societies manage and institutionalize illness. The sick role outlines a set of expectations for both the ill individual and the medical profession, helping to maintain social order during periods of health disruption. This unit also examines the crucial role of the medical profession in preserving social stability. Medicine is more than a healing practice; it is a social institution characterized by specific ethical principles and standardized conduct. Concepts such as the placebo effect, the liminal stages of illness, and the social meaning of disease (e.g., cancer) reveal that sickness is not only a biological reality but also a social event with cultural and psychological significance. By studying the evolving perspectives on the sick role, including its limitations and critiques – such as its inability to account for chronic or stigmatized illnesses – students will engage with contemporary revisions and alternative frameworks. These include a more nuanced understanding of patient agency, structural inequalities in access to care, and the diverse ways in which societies assign meaning to health and illness.



## Keywords

Sick role, Universalism, Placebo effect, Liminality, Social order

## Discussion

### ◆ *Roles of individuals*

Talcott Parsons is one of the key figures in the sociological tradition of structural functionalism, which views society as a complex system composed of interrelated parts. These parts work together to ensure stability and integration within society. Parsons believed that each structure in society performs specific functions essential for maintaining social order and harmony. Parsons conceptualized society as being built upon the performance of social roles by individuals within specific institutions. Social roles refer to the positions individuals occupy in society, such as mother, teacher, or doctor, and the corresponding responsibilities they fulfill. These roles are enacted within institutions like the family, the school, or the hospital, each of which contributes to the continuity of social life.

### ◆ *Institutions and roles*

For example, he says, family plays a fundamental role in socializing the younger generation. Through family interactions, children learn societal norms, values, and behaviors, preparing them to become functioning members of society. In the system of education, teachers in classrooms prepare the next generation for their future responsibilities, particularly in the workforce. Education instills skills and knowledge that equip individuals to contribute to society's economic and social stability. In the case of health care, doctors and medical professionals work within hospitals and clinics to restore individuals' health, enabling them to return to their roles in society. This ensures that people can continue fulfilling their responsibilities, thereby supporting the broader social system. In Parsons' view, these institutions and the roles they sustain are interconnected, working collectively to maintain the stability and continuity of society.

### **2.2.1 Health and Illness in the Broader Social Structure**

While Parsons held a favorable view of the medical profession, he also stressed the importance of understanding

health and medical practices in the context of the larger social structure. He argued that health and illness cannot be studied in isolation but must be examined in relation to other social institutions, particularly the family and the occupational structure.

- ◆ **The Family:** Families play a crucial role in supporting individuals who are sick, providing emotional care and practical assistance. They help in the recovery process, enabling individuals to resume their roles in society.
- ◆ **Occupational Structure:** The workplace and economic system are deeply tied to health. Parsons observed that individuals must be rehabilitated and restored to health so they can continue to contribute to the workforce and maintain economic stability. This interplay between health and work highlights the broader social implications of medical practices.

### 2.2.2 The Role of the Medical Profession in Social Order

Parsons gave special attention to the medical profession, which he viewed as a critical institution in maintaining social order. Illness and health, from his perspective, are not purely biological phenomena but also social constructs. The medical profession provides a framework for understanding and addressing disease, which is typically explained as a biological event or a fact of nature. However, Parsons points out that medical knowledge is often ambiguous, making it difficult to define the “facts” of illness conclusively. Parsons argued that being sick is not just a biological condition but also a social accomplishment. When a person is unwell, they take on a “sick role,” which is a socially defined status. This role comes with specific rights and obligations, such as being exempt from usual social responsibilities while seeking appropriate medical treatment to recover. In this way, illness and recovery are regulated by social norms and expectations, linking individual health to the functioning of the broader social system.

- ◆ *Maintaining social order*

#### 2.2.2.1 Characteristics of the Medical Profession

The medical profession has distinct features that define its role in society and its approach to practice. These

characteristics reflect the professionalism and ethical standards expected of doctors:

1. **Universalism in Practice:** Doctors are expected to treat all patients equally, without bias or discrimination based on class, gender, ethnicity, or religion. This principle of universalism ensures fairness and inclusivity in medical care, upholding the dignity of all individuals seeking treatment.
2. **Affective Neutrality:** Doctors maintain emotional detachment and refrain from passing moral judgments on the individuals they treat. This neutrality helps them focus on providing medical care without being influenced by personal biases or opinions about the patient's character or behavior.
3. **Orientation towards Collective Good:** The medical profession emphasizes serving the larger community rather than individual or self-serving interests. Doctors are oriented toward promoting the well-being of society by addressing public health issues and contributing to collective health outcomes.
4. **Functional Specificity:** Medical practitioners concentrate solely on addressing the health issues presented by patients. They avoid delving into unrelated personal matters, such as the patient's moral choices or lifestyle, unless it directly affects their medical condition. For example, a doctor focuses on treating a physical ailment rather than commenting on the patient's values or beliefs.

### 2.2.3 'People Act Rather than Behave'

Talcott Parsons, one of the leading figures in structural-functionalism, made a significant argument that distinguishes human action from mere behavior. According to Parsons, human beings are not passive entities who simply respond to environmental stimuli. Instead, they act with agency, making choices and decisions based on how they interpret and make sense of their surroundings. This concept of human action as purposeful and meaningful is central to Parsons' sociology and forms the foundation of his contributions to the sociology of health and illness. Parsons challenged the purely biological view of disease, which considers it a natural response of the human body to environmental factors. According to this medical model,

◆ *Individuals as active*

illness is caused by outside factors like germs, viruses, or lifestyle habits, and people have little control over it beyond their body's biology. This view sees individuals as passive victims with limited power in the process.

◆ *Meaning-making individuals*

Parsons, drawing from the ideas of Max Weber, took a different approach. He argued that humans are active agents who give meaning to their experiences, including sickness. For Parsons, disease is not merely a biological fact; it is also shaped by social, cultural, and political factors. The decision to label a condition as a "disease" is not purely scientific but is influenced by social norms, cultural beliefs, and power structures. For instance, what one society may define as a medical problem could be seen as a moral failing or even a spiritual issue in another society. This interpretation highlights the socially constructed nature of illness.

◆ *Sickness is a social condition*

Parsons also introduced the idea that sickness is a social condition rather than a purely biochemical state. To understand sickness, it is necessary to examine the broader social context in which individuals live. For example, people's access to healthcare, their cultural understanding of symptoms, and the social expectations placed upon them all influence how sickness is experienced and managed. This perspective emphasizes that illness is not simply a biological malfunction but a phenomenon deeply embedded in social relationships and cultural practices. He suggested that people actively make choices about their participation in healthcare systems and their roles as patients. For instance, individuals may decide to seek medical help, adhere to prescribed treatments, or even reject medical advice, depending on how they interpret their illness and the resources available to them. These decisions are not random but are shaped by their cultural background, social roles, and personal beliefs.

### **2.2.3.1 Why Sickness is a Social Event?**

Sickness is often understood as a condition of the body or mind, characterized by biochemical and physiological irregularities. However, sociologist Talcott Parsons challenges this purely medical perspective by arguing that sickness is fundamentally a social event. Parsons' analysis is based on two key arguments: The first addresses whether medicine can truly be regarded as a science. Medicine often claims legitimacy through its technical knowledge and scientific foundation. However, Parsons critiques this self-proclaimed status by pointing out inherent limitations within

◆ *Social conditioning of illness*

medical practice. One of his key observations involves the placebo effect, a phenomenon that became a major point of discussion in the 1950s. The placebo effect demonstrates how individuals who believe they are receiving treatment may exhibit improvements even when no actual medicine is administered. This raises questions about the purely scientific basis of medical interventions and highlights the role of belief, trust, and social interactions in the healing process.

◆ *Uncertainty of medical practice*

Parsons further argues that gaps exist in the technical knowledge upon which medicine relies. Some aspects of medical conditions are inherently unknowable, leading to situations where definitive diagnoses or effective treatments are impossible. Additionally, medical practice often involves uncertainty. For example, establishing a clear causal relationship between a health complaint, a treatment, and a cure can be challenging. These uncertainties reflect the limits of biomedical science and underscore the importance of social and cultural factors in the experience and management of illness.

◆ *Social role of sickness*

The second dimension of Parsons' argument emphasizes the social role of sickness. According to him, illness is not just a physical condition but a state that disrupts the social functioning of an individual. When a person is sick, they are temporarily exempted from their societal roles and responsibilities, such as work or family obligations. However, this exemption is conditional; the sick individual must seek treatment and strive to recover. This dynamic creates what Parsons termed the "sick role," a socially defined status that outlines expectations for both the sick individual and the broader society.

### **2.2.3.2 Placebo Effect**

The study of the placebo effect provides an essential lens through which we can understand the interaction between mind, body, and society. Daniel Moerman (2012), an American medical anthropologist and ethnobotanist, redefines the "placebo effect" by introducing the concept of the "meaning response," emphasizing that patients often respond more to the meaning and context of a treatment than to the treatment itself. Rather than focusing on inert substances, Moerman highlights how factors like the color of pills, cultural beliefs, and the doctor-patient relationship significantly influence healing. His perspective suggests

◆ *Meaning response*

that understanding these symbolic and contextual elements can lead to more effective, patient-centered care. These ideas are explored in depth in his book *Meaning, Medicine, and the 'Placebo Effect'* (2012).

◆ *Ulcer treatment*

In a study of ulcer treatment drugs, Moerman observed that up to 90% of individuals in the placebo group experienced improvement, similar to those treated with the active drug. This phenomenon, known as the placebo effect, challenges the traditional biomedical framework of Western medicine, which often separates the mind from the body and assumes that drugs exert their effects purely through biochemical interactions. Western medicine conceptualizes drugs as biochemically active substances that impact the body in predictable and measurable ways. However, the findings related to the placebo effect suggest that this perspective is incomplete. Sociologists argue that the way individuals perceive and define their experiences plays a crucial role in determining outcomes, even in situations where biological mechanisms seem to dominate.

◆ *Interpretation and reality*

This perspective is rooted in American sociologist W. I. Thomas's (1923) assertion that "*what people believe to be real will be real in its consequences.*" In other words, if a person believes they have received an effective drug, their body may respond as if they actually had – even when no active substance was administered. The broader sociological interpretation of this phenomenon emphasizes that how individuals define their situation directly affects their experiences. This means that even in cases that appear purely natural or physical – such as the administration of drugs for pain relief – social factors play an essential role in shaping outcomes. For example, cultural norms, trust in medical professionals, and expectations about treatment effectiveness can influence a person's response to a given intervention.

◆ *Sukrutham movie*

You may watch the 1994 Malayalam movie *Sukrutham*, written by M.T. Vasudevan Nair, and reflect on how Ravishankar, the main protagonist, experiences acute illness and how his belief in being cured affects his condition. Reflect on how illness and death can be understood as social events. The film highlights how Ravi's death was more socially expected than his recovery.



Figure 2.2.1 Image source: <https://alchetron.com/>

### 2.2.4 Sick Role

Talcott Parsons further developed this understanding by introducing the concept of the “sick role.” According to Parsons, illness is not just a physical condition but also a social state that involves certain roles and expectations. When individuals are unwell, they enter the sick role, which temporarily exempts them from their usual responsibilities. However, this exemption comes with obligations, such as seeking medical treatment and striving to recover. This framework demonstrates that illness is not solely a private experience but is deeply embedded in social norms and relationships. He says, the sick role is closely regulated by the medical profession. The medical profession’s task, according to Parsons, is to prevent individuals from opting out of their social roles unnecessarily, a phenomenon that could be detrimental to their health and to society as a whole.

◆ *Illness as social state*

Parsons’ focus on the ‘sick role’ reflects his broader interest in the factors that hold society together, in contrast to Karl Marx, who emphasized the aspects of society that lead to change and conflict. Parsons argued that social life would be unworkable if it relied solely on economic interests or the utilitarian pursuit of self-interest by individuals. For society to function cohesively, social institutions must counterbalance the profit motive and self-interest. Parsons viewed professions, particularly the medical profession, as key social institutions that transcend self-interest and are not solely driven by profit. These professions play a critical role in maintaining social order and stability.

◆ *Social order*

◆ *Managing sickness*

In relation to health and illness, Parsons' functionalist perspective is best illustrated through his concept of the 'sick role.' For any society to function smoothly, sickness needs to be managed in such a way that the majority of individuals continue fulfilling their normal social roles and obligations. This perspective rests on the assumption that if too many individuals were to define themselves as sick and withdraw from their social responsibilities, it would lead to dysfunction and disruption in society.

◆ *Deviation*

Parsons argued that being sick involves a temporary deviation from normal social behavior. Since sickness entails a withdrawal from regular activities and responsibilities, it can be considered a form of deviance. To ensure the efficient functioning of the social system, sickness must be managed and controlled. This is where the role of medicine becomes crucial. Medicine, as a social institution, is tasked with regulating and controlling those who identify as sick, helping them recover and reintegrate into their normal roles and responsibilities. The sick role, therefore, requires a commitment on the part of those who are unwell to seek recovery and return to normality as soon as possible.

Parsons' concept of the sick role highlights four key elements, which are systematically outlined as follows:

1. **Exemption from Social Responsibilities:** The sick individual is temporarily excused from their usual social roles and obligations, recognizing their inability to perform these tasks due to their condition.
2. **Absence of Blame:** The individual is not held responsible for their illness. Instead, society views them as deserving of care, sympathy, and support.
3. **Expectation to Seek Medical Help:** The sick person is expected to seek appropriate professional medical assistance and comply with prescribed treatments to recover from their illness.
4. **Obligation to Recover:** There is an underlying societal expectation that the individual will make a genuine effort to recover and return to their normal social roles as soon as possible.

These elements ensure that sickness is managed in a way that minimizes its disruptive impact on society, maintaining the stability and smooth functioning of the social system.

### 2.2.4.1 Limitations of 'Sick Role'

While Parsons' concept of the sick role is useful for challenging the idea of disease as purely natural and biological, it has notable limitations:

- 1. Over-reliance on Medical Practitioners:** Talcott Parsons' concept of the sick role emphasizes that individuals can only assume the status of being sick if they are legitimately defined as patients. This legitimacy is granted through the intervention of the medical profession, which operates on biologically validated grounds. In other words, the medical profession serves as the gatekeeper in determining who qualifies as sick, providing a socially and biologically accepted framework for recognizing illness. Parsons' analysis of the sick role reflects a sophisticated sociological understanding of the social function of medicine. He sought to establish a clear sociological explanation of health and disease, framing sickness not merely as a biological condition but as a socially constructed role with specific expectations and obligations. However, an ironic outcome of his theory is that, despite this sociological framing, the ultimate authority over health and illness is handed back to medical practitioners. This reliance on the medical profession highlights the tension between viewing sickness as a social phenomenon and recognizing the medical field's dominance in defining and managing health.
- 2. Special Condition of Acute and Chronic Diseases:** One key limitation is its focus on acute illnesses – temporary and episodic conditions – and its difficulty in addressing chronic illnesses, disabilities, and other long-term conditions. Chronic illnesses, such as diabetes, and physical disabilities present a challenge to the traditional sick role because they often require individuals to balance their illness with ongoing participation in social roles, rather than completely withdrawing from them. For example, individuals with diabetes may need to manage their condition while continuing to work or fulfill family responsibilities, thereby defying the expectation of a temporary suspension of social obligations. The emergence of chronic diseases has fundamentally



altered the temporal structure of the sick role. Long-term illnesses require individuals to adapt to a new normal rather than putting their lives on hold. This shift challenges the traditional assumptions of the sick role, where the expectation is that individuals will recover and return to their usual social roles. In the case of chronic conditions, recovery may not be possible, and the focus shifts to ongoing management and integration of the illness into daily life.

- 3. Condition of Stigmatized Diseases:** Parsons' model struggles with conditions that involve moral judgments alongside medical diagnoses, such as alcoholism or venereal diseases. In such cases, societal perceptions and stigmatization influence how individuals experience the sick role.
- 4. Normal yet transient experiences such as pregnancy:** They do not fit neatly into the sick role framework. Pregnancy may alter certain social roles temporarily, but it is not typically seen as a form of deviance or illness requiring medical management in the same way as acute sickness.

This reality underscores the need for a more nuanced understanding of health and illness that accounts for the diversity of experiences and the changing nature of medical and social contexts. While Parsons' concept of the sick role provides a valuable framework for understanding the social dimensions of health and illness, it is limited in its application to acute illnesses. It struggles to account for the complexities of chronic illnesses, disabilities, and morally charged conditions. These limitations highlight the evolving nature of health and illness in modern societies and the need for continued refinement of sociological theories to address these complexities.

◆ *Limitations*

#### 2.2.4.2 The Sick Role, Cancer, and Liminality

Research into the experiences of cancer patients highlights the relevance and challenges of the sick role in chronic and life-threatening conditions. For example, Little (1998) explored the lived experiences of individuals undergoing treatment for colon cancer and found that:

◆ *Cancer experience*

- 1. Enduring Identification as a Patient:** Regardless of the time elapsed since diagnosis, these individuals identified themselves as cancer patients. This ongo-

ing identification reflects the long-term impact of chronic illness, which differs from the temporary suspension of social roles assumed in Parsons' original sick role theory.

- 2. Communication Challenges:** Patients struggled to communicate the nature of their illness, its treatment, and its implications to those close to them. This difficulty underscores the emotional and social isolation often associated with chronic illnesses.
- 3. Heightened Awareness of Mortality:** A heightened sense of the passage of time and limited lifespan led to feelings of powerlessness, further complicating their social and psychological well-being.

### 2.2.4.3 The Concept of Liminality

Little introduced the concept of liminality to describe the social and emotional processes experienced by individuals with cancer. Liminality, derived from anthropological studies, refers to a transitional state in which individuals feel a diminished connection to the normal stimuli of social life.

#### Stages of Liminality

##### Stage 1: Loss of Control and Uncertainty

In the initial stage of liminality, individuals experience a profound loss of control and a sense of uncertainty. The diagnosis and treatment of cancer often lead to a disruption of normal life patterns, creating feelings of vulnerability and disorientation. This stage parallels the biological and medical experiences of illness, as patients grapple with the unpredictable nature of their condition and its outcomes.

##### Stage 2: Constructing an Illness Narrative

In the second stage, individuals attempt to make sense of their experiences by constructing an illness narrative. This process involves creating a coherent story about their illness, which serves two essential functions:

- 1. Understanding Personal Experiences:** By framing their experiences within a narrative, individuals can find meaning and a sense of purpose, which helps restore a degree of control over their situation.
- 2. Facilitating Communication:** Narratives enable individuals to communicate their experiences to oth-



ers, fostering understanding and empathy. This step helps rebuild weakened social connections and mitigates feelings of isolation.

#### 2.2.4.4 Evolving Perspectives on the Sick Role

##### ◆ *Alternative concepts*

Research into cancer and other chronic illnesses reveals significant limitations in the traditional concept of the sick role. Unlike acute illnesses, which often involve temporary withdrawal from social roles, chronic conditions require patients to adapt to ongoing management while maintaining their societal responsibilities.

The concept of the empowered sick individual and the notion of liminality provide alternative frameworks for understanding these experiences. They emphasize the importance of:

- ◆ Acknowledging the long-term and evolving nature of chronic illnesses.
- ◆ Addressing the emotional and social dimensions of illness, including isolation, communication barriers, and identity shifts.
- ◆ Recognizing the active role individuals play in navigating their health challenges and redefining their social roles.

##### ◆ *Relevance*

The concept of the sick role, as proposed by Talcott Parsons, continues to inspire research in contemporary sociology and health studies. Although its traditional framework has faced criticism for its limitations, the theory remains a valuable tool for exploring the social dimensions of health and illness. One of the significant extensions of the sick role theory is the notion of the empowered sick individual, who takes an active role in managing their condition. This framework shifts the focus from a passive acceptance of the sick role to a more dynamic, proactive approach where individuals adopt positive attitudes toward their health challenges.

## Summarised Overview

This unit offered a comprehensive understanding of health and illness from a structural–functional perspective, particularly through the lens of Talcott Parsons’ concept of the *sick role*. Health was explored not only as a biological condition but as a social institution crucial for maintaining the stability and functioning of

society. Illness, from this viewpoint, is seen as a form of deviance that temporarily removes individuals from their social roles. To manage this disruption, Parsons introduced the sick role – a set of expected behaviors for both the sick individual and the medical professional – to guide the return to normalcy.

The unit emphasized how the medical profession plays a key role in maintaining social order by managing and legitimizing illness. Students learned about the defining characteristics of the medical profession – universalism in practice, affective neutrality, orientation toward the collective good, and functional specificity – which uphold the ethical and professional standards essential for impartial and effective care. These values not only guide the behavior of healthcare professionals but also reflect broader societal norms regarding fairness, responsibility, and scientific detachment. Concepts such as the placebo effect, the social event nature of sickness, and the experience of liminality in chronic illnesses like cancer deepened students' understanding of how illness is interpreted, managed, and given meaning within different social contexts. Through this critical lens, learners were equipped to analyze how the relationship between patients, doctors, and society is dynamic and embedded in broader cultural and institutional frameworks.

## Self-Assessment Questions

1. Who stated that “what people believe to be real will be real in its consequences”?
2. Which sociologist introduced the concept of the ‘Sick Role’?
3. What is the meaning of ‘Affective Neutrality’?
4. What do you understand by the term ‘Placebo Effect’?
5. Briefly explain the concept of *liminality* in the context of acute illness.
6. Critically examine the role of the medical profession in maintaining social order.
7. Comment on the statement: “People act, rather than behave.” What does it imply in the context of health and illness?
8. Elucidate the concept of the ‘Sick Role’ with appropriate examples.



## Assignments

1. Critically examine Talcott Parsons' concept of the sick role. In what ways does it contribute to our understanding of health and illness as socially structured experiences, and what are its limitations in addressing chronic illnesses and mental health conditions?
2. Discuss the role of the medical profession in maintaining social order from a structural-functional perspective.
3. "Sickness is not merely a biological event, but a social event." Analyze this statement using examples such as the placebo effect, cancer, and the concept of liminality.
4. How does the structural-functional approach explain the relationship between health, illness, and the broader social structure?
5. Evaluate the relevance of Parsons' sick role in contemporary society. Consider evolving perspectives on illness, patient autonomy, and the transformation of the doctor-patient relationship in light of medical pluralism and social change.

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SGOU



## Health and Symbolic Interactionist Perspectives

### Learning Outcomes

After reading this unit, the learner will be able to:

- ◆ comprehend the symbolic interactionist perspective of health
- ◆ examine the social construction of illness and stigma
- ◆ analyze Goffman's studies on total institutions and mortification of self
- ◆ familiarize themselves with the labeling approach of health and illness

### Background

Symbolic Interactionism, a sociological perspective rooted in the work of theorists like George Herbert Mead and Herbert Blumer, posits that objects, events, and experiences derive their meaning through human interaction with others and the environment. According to this framework, meaning is neither inherent nor static; rather, it is shaped, negotiated, and transformed through continuous social interaction and interpretative processes. This perspective is particularly insightful in understanding illness, as it shifts the focus from purely biological explanations to the subjective meanings and experiences that individuals and societies attach to health and disease.

Symbolic Interactionists emphasize the social and cultural context in which illness is experienced. They argue that the meanings people attribute to illness are not universal but are influenced by the interactions and interpretations that occur within their specific social and cultural environment. For instance, an individual's perception of illness may depend on cultural norms, personal experiences, or the reactions of others within their social circle. These meanings are not fixed; they are constantly being reassessed and redefined through ongoing interactions.

This unit will introduce you to these aspects. It explores the everyday experiences of those living with illness, particularly chronic conditions, and how these experiences disrupt biographical narratives, often leading to what scholars describe as a "loss of self." It examines how individuals adapt to illness,



renegotiate their identities, and develop new coping mechanisms, highlighting the dynamic interplay between personal agency and social structures.

## Keywords

Social construction, Stigma, Mortification, Total institutions, Medicalization

## Discussion

### 2.3.1 Symbolic Interactionism and Social Construction of Illness

This theoretical approach has been expanded upon by American medical anthropologist Arthur Kleinman, who explored how individuals and communities interpret and respond to illness. In his seminal work, *Patients and Healers in the Context of Culture* (1980), Kleinman introduced the concept of “explanatory models” to describe the frameworks people use to make sense of illness. These models reflect the cultural and social narratives through which individuals and groups interpret the causes, symptoms, and treatments of a particular condition. Kleinman demonstrated that these explanatory models vary widely between different societies and even between patients and healthcare providers within the same culture, leading to diverse understandings of illness and healing practices.

◆ *Theoretical approach*

For example, in some cultures, illness may be attributed to supernatural forces, moral transgressions, or imbalances in the body, while in others, it may be understood through biomedical frameworks. It is interesting to note that British anthropologist Edgar Thurston (1909) discussed how epidemics such as smallpox and cholera were perceived as supernatural agents in northern Kerala. You can observe such incidents even today. These interpretations shape how individuals seek treatment, comply with medical advice, and experience the social implications of their condition. Kleinman’s work underscores the importance of understanding these culturally embedded explanatory models to provide effective and empathetic healthcare, especially in cross-cultural contexts.

◆ *Social implications*

◆ *Social interaction*

Social constructionism highlights that the meanings attributed to phenomena are not inherent but arise through social interactions within specific contexts. This perspective, as articulated by Berger and Luckmann (1966), focuses on how individuals and groups collectively shape perceived social realities and knowledge. It suggests that our understanding of the world is not solely objective but deeply influenced by cultural and social systems. The emphasis is on how the meanings of phenomena do not necessarily inhere in the phenomena themselves but develop through interaction in a social context. In another way, social constructionism examines how individuals and groups contribute to producing *perceived social reality and knowledge*.

◆ *Social context*

Symbolic interactionists argue that health and illness are social constructions. This means that physical and mental conditions do not have an objective reality independent of societal definitions. Instead, the meaning and experience of illness depend on how these conditions are understood and treated within a specific cultural and social context. For example, in the case of Pregnancy, infertility and Childbirth, Societal norms and cultural beliefs heavily shape how pregnancy and childbirth are experienced. In some societies, these processes are celebrated as natural milestones. In some societies, they are medicalized and treated as conditions requiring constant monitoring and intervention. In India, infertility is heavily stigmatized due to cultural norms that equate motherhood with a woman's primary role. Scholars like Kalpana Ram (2011) have studied how women face immense pressure to conceive and are often blamed, excluded, or abandoned if they struggle with infertility. Deep-rooted beliefs, lack of awareness, limited healthcare access, and financial constraints worsen their plight, leading to mental health issues.

◆ *Disability*

Disability provides another example of the social construction of illness. Goffman's insights into stigma highlight that the challenges faced by individuals with disabilities often stem less from the impairment itself and more from societal attitudes and structural barriers. For instance:

- ◆ A physical impairment like being in a wheelchair is not inherently stigmatizing. The stigma arises from inaccessible public spaces or assumptions about a disabled person's capabilities.

- ◆ Cultural attitudes toward disability influence how individuals with impairments are treated, perceived, and integrated into society.

### 2.3.2 Chronic Illness, Biographical Disruption, and the Loss of Self

◆ *Discontinuity*

The experience of chronic illness has been widely studied within sociology and social psychology, particularly focusing on how such conditions disrupt an individual's life narrative and self-identity. Chronic illness introduces what is often referred to as "biographical disruption," a concept that captures the way in which long-term illness disrupts the continuity of one's life story, creating a fracture between the past, the present, and the imagined future. In this context, individuals often face a "loss of self," as their previous roles, identities, and expectations are overshadowed by the realities of managing illness.

◆ *Lived experience of patients*

This theoretical perspective delves into the social psychology of chronic illness, with a strong emphasis on the lived experiences of patients and the meanings and actions that emerge in their everyday lives. Key studies have illuminated this phenomenon in significant ways. For example, *Passage through Crisis: Polio Victims and Their Families* (1960) by Irving Kenneth Zola explores how polio patients and their families live with the psychological and social challenges of the disease. Similarly, *Chronic Illness and the Quality of Life* (Glaser and Strauss, 1979) investigates how individuals adapt to living with chronic conditions, while *Having Epilepsy: the Experience and Control of Illness* (1983) provides insights into how epilepsy patients manage their lives while dealing with stigma and unpredictability. Michael Bury's influential study, *Chronic Illness and Biographical Disruption* (1982), introduced the term "biographical disruption" and explored how individuals redefine their lives and identities in the face of chronic illness.

◆ *Managing sickness*

These studies collectively reveal a common theme: for individuals living with chronic illness, the primary goal often shifts from seeking a cure to managing daily life. The emphasis lies on practical and psychological strategies to control symptoms, maintain routines, and avoid the stigmatization often associated with chronic conditions. Living with chronic illness becomes an ongoing negotiation between one's physical limitations and social expectations, where patients must reconcile their illness with their roles in

family, work, and community life. This shift in focus reflects a significant reorientation in patients' lives. Managing chronic illness entails learning to adapt to new physical realities, restructuring daily routines, and coping with the uncertainty that accompanies such conditions. For many, this process involves not only practical adjustments but also emotional and social challenges, as they live with altered relationships, changing self-perceptions, and societal attitudes toward illness and disability.

### 2.3.2.1 Living with Chronic Illness

George Herbert Mead, a foundational figure in symbolic interactionism, posited that the self is not an inherent attribute but a dynamic construct shaped through social processes. According to Mead, the self emerges and evolves as individuals interact with others and interpret their lives within specific social contexts. In this framework, chronic illness acts as a significant disruption, fundamentally altering an individual's sense of self, identity, and life narrative. It forces individuals to confront and reconfigure their understanding of themselves, as their previous roles and interactions are often transformed by the limitations and challenges imposed by illness.

◆ *Disruption*

Veena Das, in her seminal work *Affliction: Health, Disease, Poverty*, extends this discussion by exploring how tragedies and illnesses, particularly in marginalized communities, disrupt everyday life. For individuals living in poverty, illness often arrives as an uninvited and overwhelming shock—what she refers to as “diagnostic shock.” This term captures the abrupt and often disorienting impact of receiving a diagnosis, particularly in contexts where access to healthcare is limited and societal support is minimal. Illness in such settings not only challenges an individual's physical health but also affects their social interactions, routines, and ability to maintain a coherent sense of self. Das emphasizes that for the marginalized, illness becomes entwined with broader struggles of survival and vulnerability, shaping how individuals live their lives in the face of adversity.

◆ *Diagnostic shock*

### 2.3.3 Total Institutions and Mortification of Self

Canadian sociologist Erving Goffman, another prominent figure in symbolic interactionism, offers further insights into the formation of self in contexts of social disruption. In his classic work *Asylums: Essays on the Social Situation of*



◆ *Institutional environment*

*Mental Patients and Other Inmates* (1961), Goffman examines how the self is reconstructed in “total institutions” such as mental hospitals. These institutions, which exercise complete control over the lives of individuals, deeply alter the self-perception and identity of their residents. Goffman’s analysis demonstrates how the institutional environment redefines social roles and interactions, often stripping individuals of their previous identities and imposing new ones shaped by the rules and norms of the institution. Goffman’s concept of total institutions provides an insightful understanding of how certain social settings structure the lives of individuals under strict bureaucratic control. Total institutions are characterized by their capacity to govern nearly every aspect of an individual’s daily life, often through mechanisms that reshape identity, behavior, and autonomy. These institutions operate through what Goffman refers to as the “mortification of self,” a process in which an individual’s previous identity is systematically eroded and replaced by an institutional identity.

### 2.3.3.1 Characteristics of Total Institutions

Goffman defines total institutions as organized social settings in which individuals sharing similar circumstances (e.g., prisoners, patients, or soldiers) live under a unified and centralized system of authority. These institutions are distinct from everyday social life in several ways:

1. **Unified Control and Single Authority:** In total institutions, daily life unfolds in a single, enclosed location where all activities are controlled by a central authority. Unlike civil society, where individuals work, rest, and socialize in different spaces with varied authorities, total institutions merge all these activities under one administrative system.
2. **Collective Activities:** Individuals in total institutions often engage in daily activities in the presence of others in similar circumstances. These activities are highly regimented and frequently performed in groups, reinforcing the institution’s control over individuals.
3. **Highly Structured Routines:** The daily schedule in all institutions is meticulously planned. Activities such as eating, sleeping, working, and recreation are sequenced and synchronized to meet the organizational goals rather than individual needs.

### 2.3.3.2 Types of Total Institutions

Goffman identified five types of total institutions, each serving a different purpose:

1. **Prisons** – Designed to confine individuals deemed a threat to society.
2. **Asylums** – Established for the care of individuals with mental illnesses.
3. **Military Barracks** – Facilities that train and discipline individuals for national defense.
4. **Religious Orders** – Institutions like monasteries, where individuals retreat from society for spiritual goals.
5. **Other Care Facilities** – Such as nursing homes, where individuals requiring long-term care are housed.

### 2.3.3.3 The Process of Mortification of Self

The defining feature of total institutions is the process of the *mortification of self*. This term refers to the systematic stripping away of an individual's prior identity and autonomy to enforce conformity within the institution. Goffman outlines several stages and mechanisms involved in this process:

1. **Role Dispossession:** Individuals lose their previous roles and identities from civil society and are instead assigned roles defined by the institution, such as "patient," "inmate," or "recruit." This leads to what Goffman calls *disculturation*, a detachment from one's past self.
2. **Programming and Identity Trimming:** The institution often reduces an individual's identity to a series of numerical or administrative records, erasing the complexities of their personal life.
3. **Dispossession of Property and Identity Kits:** Personal belongings, which signify individuality, are confiscated or restricted. Items that reinforce a sense of personal identity, such as clothing or personal effects, are replaced with standardized items provided by the institution.
4. **Imposition of Degrading Behaviors:** Individuals



are subjected to routines and postures that may feel humiliating. These practices, such as medical examinations or uniforms, are often justified as necessary for the institution's functioning.

5. **Contaminative Exposure:** Privacy is severely limited. Individuals are often required to perform private activities, such as bathing or eating, in public or semi-public settings, further diminishing personal boundaries.
6. **Loss of Autonomy over Actions:** In total institutions, even routine actions like making a cup of tea or deciding when to sleep are governed by the institution's rules. This disrupts the usual relationship between the individual and their behavior.
7. **Restrictions on Freedom and Self-Determination:** Individuals experience significant restrictions on their ability to make decisions, pursue interests, or form relationships. These limitations often stem from the institution's bureaucratic controls rather than the individual's physical or mental condition.

The rigid structure and control in total institutions often have effects on the individual's sense of self and autonomy. The longer one stays in such an institution, the deeper the *mortification of self* becomes, making reintegration into broader society challenging. However, Goffman also notes that short episodes of care or confinement, such as brief hospital stays, may avoid the totalizing effects of these institutions. Moreover, the degree of totalization is influenced by how much the institution excludes individuals from decision-making about their treatment or care. For instance, a patient who is actively involved in their treatment plan may retain a greater sense of autonomy compared to one who is entirely excluded from such processes.

◆ *Self autonomy*

### 2.3.4 Social Construction of Stigma

The concept of stigma plays a central role in understanding how society perceives and responds to illness. A stigma is an attribute, behavior, or reputation that is socially dishonored in a way that causes individuals to be labeled as "undesirable" or "abnormal." This classification results in rejection or marginalization, challenging an individual's ability to integrate into social life. The roots of the concept of stigmatized illness can be traced to Erving Goffman's

◆ *Stigma*

influential work *Stigma: Notes on the Management of Spoiled Identity* (1963). Goffman argued that the stigma associated with physical impairments or illnesses is not inherent in the condition itself but arises from social interactions and cultural perceptions. Building on Goffman's work, Gussow and Tracy (1968) introduced the term *stigmatized illness* to describe conditions such as leprosy. Since then, researchers have explored the stigma surrounding various illnesses, including:

- ◆ **Mental Illness:** Often stigmatized due to misconceptions about danger, unpredictability, or personal weakness.
- ◆ **Epilepsy:** Historically associated with supernatural beliefs, leading to discrimination.
- ◆ **Cancer:** Once considered a “death sentence,” cancer has been stigmatized due to fear and misinformation.
- ◆ **HIV/AIDS:** Deeply stigmatized due to its association with marginalized groups and myths about transmission.
- ◆ **Sexually Transmitted Diseases (STDs):** Frequently stigmatized because of moral judgments attached to sexual behavior.

Stigma often impacts what Erving Goffman refers to as an individual's *virtual social identity*—the expectations others have about a person, contrasting it with their *actual social identity*, which is who they truly are. Illness-related stigma can shape an individual's sense of self and social relationships.

Examples of illnesses associated with stigma include:

- ◆ **Obesity and Alcoholism:** These conditions have historically been stigmatized due to their perceived connection with personal choices or moral failings. However, societal attitudes are shifting. For instance, movements such as *fat pride* and *fat acceptance* challenge traditional stigmas surrounding obesity, emphasizing body positivity and self-acceptance.
- ◆ **Homosexuality:** Homosexuality was once classified as a mental disorder by the American Psy-



chological Association (APA) until 1973. Over time, societal perceptions have evolved, and homosexuality is now widely recognized as a natural variation of human sexuality, contributing to reduced stigma in many parts of the world.

#### 2.3.4.1 Medicalization of Behavior

In some cases, behaviors that were once considered moral or social failings have been redefined as medical conditions. This process, known as *medicalization*, reflects society's tendency to attribute deviant behaviors to underlying physical or mental health issues. Examples include:

- ◆ Alcoholism (now seen as a disorder rather than merely a lack of willpower).
- ◆ Fatigue and insomnia (increasingly treated as medical conditions requiring intervention).
- ◆ Hyperactivity (often diagnosed and managed as ADHD).

Medicalization transforms how individuals and societies interpret and respond to behaviors, often reducing stigma by framing them as health issues rather than moral shortcomings.

#### 2.3.5 Labelling Approach

Labeling theory, developed by sociologists during the 1960s, challenges the notion that deviance is an inherent characteristic of an act. Instead, it argues that deviance is socially constructed through the process of labeling by society. This theory emphasizes how dominant groups or majorities tend to label minorities or individuals who deviate from standard cultural norms negatively. These labels can significantly influence an individual's behavior and self-identity, shaping how they see themselves and how others perceive them.

- ◆ *Social construction of deviance*

Labeling theory is closely linked to the concepts of social construction and symbolic interactionism. It highlights how social reactions and classifications influence individuals' self-perceptions and behaviors. Through stereotyping and the process of labeling, individuals are often pushed into roles or behaviors that align with the labels society assigns to them. This process underscores the power of social interactions and perceptions in shaping individual identities and societal norms, particularly in the context of health, illness, and

◆ *Labeling process*

deviant behavior. The social construction of deviant behavior is central to the labeling process in society. Deviance is not an absolute concept; rather, it is created and defined by cultural norms, which vary across societies and groups. Labeling theory was first applied to the concept of mental illness in 1966 when Thomas J. Scheff published *Being Mentally Ill*. In this work, Scheff challenged conventional views on mental illness, suggesting that mental illness is not a biological or inherent condition but is instead a result of social labeling and influence.

◆ *Types of labeling*

The theory also distinguishes between two perspectives on mental illness: hard labeling and soft labeling. Hard labeling proponents argue that mental illness does not exist as a real condition. They believe that what is perceived as mental illness is merely a deviation from societal norms, leading people to categorize it as an illness mistakenly. On the other hand, soft labeling proponents accept that mental illnesses do exist but argue that social factors contribute significantly to their construction and perception. Unlike hard labeling, soft labeling does not entirely dismiss the existence of mental illness but sees it as influenced by social and cultural contexts.

◆ *Self-fulfilling prophecy*

Several key terms are associated with labeling theory. The concept of a *self-fulfilling prophecy* plays an important role, as it refers to a situation where a label or prediction leads an individual to behave in a way that makes the label true. For example, labeling someone as “deviant” may lead them to adopt deviant behaviors. Social construction refers to the idea that certain concepts or practices are not universal but are created and understood differently by various social groups and institutions. Finally, deviance is defined as actions or behaviors that violate cultural norms, whether formal norms like laws or informal ones, such as acceptable social behaviors.

◆ *Labeling of diseases*

The stigmatizing effects of labeling are not limited to mental illness but extend to other issues. For example, during the rise of HIV/AIDS cases among gay men in the 1980s, the disease was labeled as a “homosexual disease.” This label reinforced the perception of homosexuality as deviant and immoral. Even today, some people continue to view HIV/AIDS as a punishment for what they see as inappropriate sexual behaviors. Such labeling has had a lasting impact on how individuals and communities are perceived, contributing to stigma and discrimination.

◆ *Positive impact*

While labels can be stigmatizing, they also have the potential to lead individuals toward treatment and recovery. Being labeled as “mentally ill” can encourage individuals to seek help, such as psychotherapy or medication. This perspective suggests that labeling may play a positive role in helping society identify those in need of support. However, critics argue that categorizing individuals based on diagnostic labels is not the only approach to addressing mental health. Spectrum or continuum models, for instance, offer an alternative framework. These models suggest that people vary along different dimensions of mental health, with everyone falling at different points on a spectrum. Such approaches avoid rigid classifications and emphasize the complexity and individuality of human experiences, offering a more flexible understanding of mental health.

## Summarised Overview

From this unit, you have learned about the social construction of illness, which reveals how societies define what counts as “ill” or “healthy,” who gets labeled, and how these labels impact identities and life trajectories. Living with chronic illness becomes an ongoing process of adaptation and meaning-making. Patients negotiate their identities not just in private but in interaction with others – family, friends, caregivers, and healthcare professionals. The everyday experience of illness thus becomes an arena where individuals work to manage impressions, resist stigma, and reclaim agency. This unit also introduced Erving Goffman’s concept of total institutions, which are social spaces such as prisons, asylums, military barracks, religious orders, and long-term care facilities. These institutions are characterized by unified authority, regimented group activities, and highly structured routines. In such settings, individuals undergo what Goffman called the “mortification of self” – a process in which previous identities are stripped away through a series of formal and informal practices, leading to the reconstruction of the self according to institutional norms.

A critical dimension of these experiences is the social construction of stigma. Illness, especially mental or chronic illness, often carries a stigma that separates individuals from “normal” society, labeling them as deviant or deficient. The labeling approach in symbolic interactionism shows how such labels can have real social consequences, affecting treatment, self-esteem, and access to resources. Furthermore, the medicalisation of behavior – where non-medical issues are redefined as medical problems – has expanded the power of medical institutions and professionals in classifying and controlling various forms of human behavior.

## Self-Assessment Questions

1. Who authored the book *Stigma: Notes on the Management of Spoiled Identity*?
2. What is meant by *biographical disruption*?
3. What is the meaning of *contaminative exposure*?
4. What is meant by *identity trimming*?
5. Explain the concept of social stigma associated with illness. Provide relevant examples.
6. Briefly explain the *labeling approach* in medical sociology.
7. Discuss the concept of the *social construction of illness*, citing key scholarly works.
8. Critically examine Goffman's studies on *total institutions*. What are their implications for understanding institutional life and illness?

## Assignments

1. Discuss the significance of symbolic interactionism in understanding health and illness.
2. Critically examine the experience of chronic illness through the lens of "biographical disruption" and "loss of self."
3. Analyze the characteristics and functioning of total institutions, and explain the process of "mortification of self" using the examples of your choice.
4. How does the social construction of stigma affect individuals with chronic or mental illness? Discuss using concepts from the labelling approach and symbolic interactionist theory.
5. Provide sociological insights into how certain behaviors become medicalised and the role institutions play in this transformation.



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## Space for Learner Engagement for Objective Questions

Learners are encouraged to develop objective questions based on the content in the paragraph as a sign of their comprehension of the content. The Learners may reflect on the recap bullets and relate their understanding with the narrative in order to frame objective questions from the given text. The University expects that 1 - 2 questions are developed for each paragraph. The space given below can be used for listing the questions.

SGOU





## Medical Discourse: Michel Foucault and Ivan Illich

### Learning Outcomes

After reading this unit, the learner will be able to:

- ◆ comprehend the critical thoughts of Michel Foucault and Ivan Illich
- ◆ analyse Foucault's works on medical discourse, power and body
- ◆ explain Ivan Illich's concept of medical nemesis

### Background

The field of medical sociology has evolved beyond the study of illness and healthcare systems to include a deeper inquiry into the cultural, political, and philosophical foundations of medical knowledge and practice. Thinkers like Michel Foucault and Ivan Illich have significantly influenced the way we understand medicine—not just as a healing science, but as a discourse deeply embedded in power, control, and social organization. Their works challenge the conventional, taken-for-granted assumptions about the neutrality and beneficence of medical institutions. They expose how medicine functions as a political tool, shaping norms, controlling bodies, and regulating populations through mechanisms of surveillance, categorization, and normalization.

Michel Foucault's analysis of medical discourse—especially in his seminal works *The Birth of the Clinic* and *The History of Sexuality*—reveals how modern medicine emerged alongside institutional forms of power and surveillance. Concepts such as anatomopolitics and biopolitics show how the human body and life itself become objects of political strategy. Ivan Illich, on the other hand, offers a more radical critique of modern medicine in *Medical Nemesis*, warning against the growing medical monopoly, iatrogenic harm, and the moral authority medicine assumes in defining life, death, and human values. Both thinkers emphasize that medicine is not merely a scientific enterprise, but a powerful social institution that shapes our understanding of the body, health, and even morality. This unit invites you to engage with these critical perspectives.



# Discussion

## Introduction

- ◆ *Power is not neutral*

Michel Foucault's analysis of power and knowledge influences how we understand the construction of illness in modern societies. He argued that knowledge is not neutral or objective; instead, it functions as a form of power that shapes and regulates human life. Foucault emphasized that expert knowledge, particularly about human "normality" and "abnormality," plays a crucial role in exercising power. This knowledge, far from being naturally given, is socially constructed and serves as a principal mechanism of control in contemporary societies.

- ◆ *Role of professional groups*

Foucault, like Parsons and in contrast to Marx, emphasizes that modern societies cannot be understood solely through economic frameworks. Drawing from Max Weber, he highlights the rise of bureaucratic systems that monitor and regulate populations as a defining feature of contemporary society. A key aspect of Foucault's analysis is the role of professional groups who claim both the knowledge to understand human behavior and the authority to dictate how individuals should act. Medicine serves as an illustrative case in Foucault's historical analysis, showcasing how it shapes our understanding of the body and disease. His concepts of "anatomy-politics" and "biopolitics" further explain the intersection of individuals and social structures. Anatomy-politics refers to the internalization of scientific notions of health and normality, administered by professionals asserting expertise. Biopolitics, on the other hand, connects the human body to organized systems of knowledge, facilitating social control and regulation. Together, these concepts link individual behavior to broader social structures.

### 2.4.1 Medical Discourse

Foucault says Medical discourse, in particular, is a powerful tool for constructing knowledge about the human body and disease. According to Foucault, the language and frameworks used in medicine are not merely descriptive but actively shape our understanding of health, illness, and the body itself. Bryan Turner (1995) reinforces this idea, asserting that diseases cannot be regarded as natural events existing independently of the language used to describe them. The way diseases are identified, named, and categorized through

◆ *Medical behavior*

medical discourse frames how individuals and societies perceive them, influencing cultural norms and expectations. This constructed knowledge has far-reaching implications. Medical discourse can shape individuals' behaviors and subjective experiences, impacting how they perceive and embody their health conditions. For instance, a diagnosis not only labels a biological condition but also carries with it a social meaning that can influence a person's sense of identity. Additionally, medical discourse legitimizes certain interventions and treatments, often reinforcing the authority of medical professionals and institutions in regulating human lives.

◆ *Creation of norms*

Foucault's analysis also reveals how medical discourse creates norms around health and illness that dictate what is considered "normal" or "abnormal." These norms have a regulatory function, subtly guiding how individuals should act and how their bodies should be managed. As a result, medical discourse extends beyond treating diseases—it constructs realities that affect how society operates, reinforcing power dynamics and shaping collective understanding of health. In this way, the power of medical discourse lies not just in diagnosing and treating illness but in defining the boundaries of normality and abnormality, shaping identities, and legitimizing interventions. By examining the social and cultural dimensions of medical knowledge, Foucault challenges the assumption that medicine is a purely objective field, revealing its role in constructing and regulating the lived experiences of illness in modern societies.

◆ *Parallels between Foucault and Parsons*

Parsons and Michel Foucault share significant parallels in their analysis of medicine. Both argue that medicine is not primarily about healing but functions as a mechanism of social control. They challenge the notion of medicine's scientific objectivity and examine how sickness is constructed as deviance in modern society. For Parsons, entering the "sick role" allows individuals to escape social obligations, representing a form of motivated deviance. Foucault, on the other hand, emphasizes how modern "helping professions," such as medicine, label individuals as diseased, thereby exercising control. In Foucault's framework, Parsons' sick role is seen as one aspect of a broader system of internalized self-control, where individuals adopt ideals of "normal" behavior to align with societal expectations.

◆ *Disciplinary power*

### 2.4.1.1 Power, Surveillance, and Society

Foucault critiques the traditional focus on economics as central to modern society, particularly in Marxist theory. Instead, he highlights the role of administrative power, which has evolved alongside modern social sciences like criminology, psychology, sociology, and medical sciences. Modern societies are characterized as bureaucratic, requiring the systematic collection, monitoring, and evaluation of information to govern effectively. Foucault introduces the concept of *disciplinary power*, contrasting it with the overt violence used in earlier times. While state-controlled violence remains a hidden threat, disciplinary power operates through surveillance. Surveillance has two key aspects:

1. Gathering and organizing information to monitor populations.
2. Direct supervision within institutions such as schools, factories, prisons, and hospitals.

### 2.4.1.2 Anatomopolitics and Biopolitics

Foucault links these ideas through the concepts of *anatomopolitics* (the politics of the body) and *biopolitics* (the politics of population). These concepts describe how modern states exercise control over individuals and populations to ensure health, productivity, and longevity.

- ◆ **Anatomopolitics** focuses on the body as a machine, emphasizing discipline, efficiency, and control to maximize its productivity and obedience.
- ◆ **Biopolitics** addresses the population as a whole, managing aspects like birth rates, mortality, health, and life expectancy through regulatory measures and interventions.

◆ *Interplay*

For Foucault, modern society revolves around the interplay of power, knowledge, and the body. Power is not confined to specific groups but is present in all social relationships, functioning like an electrical field. The body becomes both the target and the product of power, shaped through disciplinary practices and internalized self-control. Medical power, in this sense, is relational – those subjected to it also influence and respond to it, making power dynamic and interactive. This perspective provides an understanding of how modern societies govern through subtle yet pervasive mechanisms, shaping individuals and populations alike.

### 2.4.1.3 Birth of the Clinic and Medical Discourse

#### ◆ Transformations

Michel Foucault's *The Birth of the Clinic* (1973) explores how medical knowledge is shaped by its historical context. He argues that modern medicine reflects the rise of an "administered society," where centralized information about citizens becomes essential for social planning. Foucault's analysis emphasizes the demographic transition of the late 18th and 19th centuries, when declining mortality rates and rising urbanization brought new challenges. As cities expanded and capitalism matured, governments developed new methods to study and manage populations. This shift, Foucault argues, marked a transformation in power dynamics, where traditional, violent, and ritualistic forms of control gave way to more subtle, calculated mechanisms of governance. He believed that the growth of modern cities and the accumulation of capital went hand in hand with the "accumulation of men," creating a system of surveillance and subjugation.

#### ◆ Knowledge about people

Michel Foucault's concept of "power/knowledge" explores how knowledge about people became a tool for control and surveillance. During the rise of modern society, disciplines like sanitary science, penology, medicine, and industrial hygiene emerged. These fields focused on studying individuals and their lifestyles to predict, monitor, and regulate their behavior. Foucault connects the academic "disciplines" (such as psychology, psychiatry, medicine, and the social sciences) to the idea of discipline as a means of enforcing norms and prescribing appropriate behaviors. These disciplines not only generated knowledge but also created standards that shaped how individuals should act, thus reinforcing social control. For Foucault, knowledge is never neutral—it is always intertwined with power, extending beyond economic structures to credentialed knowledge produced by institutions like universities.

#### ◆ Normalising system

Foucault's key insight is that the development of modern social and medical sciences represents the growth of a sophisticated system of power/knowledge designed for social control. Professional groups like doctors and psychiatrists played a role in normalizing these systems, while individuals internalized these norms as subjective realities. The knowledge produced by these disciplines categorized people into groups such as the sane, insane, deviant, criminal, or sick, establishing scientific criteria for judgment and exclusion.

## 2.4.2 Foucault's History of Medicine

Foucault's historical analysis of medicine highlights three distinct periods, each reflecting changing relationships between patients, doctors, and the understanding of disease.

### 1. Bedside Medicine (Middle Ages to 18th Century):

During this period, medical care was holistic. Doctors depended on the favor of their patients, and disease was understood as a disruption of the individual's overall balance, involving both physical and spiritual factors. The central question was, "What is the matter with you?" emphasizing the patient as a whole person. The doctor-patient relationship was personal, and treatment focused on the individual's overall well-being.

### 2. Hospital Medicine (19th Century):

The Industrial Revolution and urbanization led to the establishment of large hospitals, marking a shift in medical practice. Disease was no longer seen as affecting the entire person but was localized to specific organs. The doctor's role became professionalized, and the question, "Where does it hurt?" reflected a narrow focus on physical symptoms. Patients were now dependent on doctors and had to comply with their authority to receive treatment.

### 3. Laboratory Medicine (Mid-20th Century Onward):

In this period, scientific testing and laboratory research took center stage. Disease was conceptualized as a biochemical process at the cellular level, and statistical tests replaced the personal relationship between doctor and patient. The patient's role diminished further as healing depended on the results of scientific tests rather than the doctor's personal insight or charisma. This shift is reflected in the phrase, "Let's wait and see what the tests say."

## 2.4.3 Discourse on Body

The study of the body has emerged as a significant research area due to both social changes and developments in sociological theory. Changes in social life, such as the aging population in capitalist societies and lower death rates in developing nations, have made the body a central topic in anthropology, history, philosophy, and sociology. The body, seen as a carrier of commodities and lifestyles, symbolizes social status through practices like fitness routines and



◆ *Medical advancements*

fashion. Medical advancements challenge traditional notions of a “natural” body, emphasizing its social construction. For instance, debates on organ transplants and definitions of death underscore how professional interests influence our understanding of the body and personhood. This growing interest spans from popular media to scholarly studies, emphasizing the body’s role as a socially constructed entity.

◆ *Body as a motor*

Historically, conceptualizations of the body have evolved. In medieval times, the body was seen as a reflection of divine order, where physical ailments were tied to spiritual causes. During the modern period, Descartes’ philosophy likened the body to a machine, emphasizing a dualistic view where the body and mind were distinct. This perspective influenced medical and psychological sciences, prioritizing physical explanations and scientific methods for studying human beings. The body serves as a site of complex interactions between society, the individual, and social power. In the 19th century, physiology books gained popularity among urban audiences, portraying the body as a symbol of order and progress, mirroring industrial society’s values. Concepts like “consensus” in politics were drawn from physiological terms, illustrating the exchange of ideas between natural and social sciences. This period also saw the rise of the metaphor of the “human motor,” where the body was linked to industrial machines and natural forces, symbolizing the era’s vision of social modernity.

◆ *Body as a social construct*

Foucault argues that the concept of the human body is not a natural, unchanging entity but a historical and cultural construct shaped by political and economic regimes. He suggests that ideas about the body and disease are products of specific historical and political contexts, rather than universal truths. The body, he explains, is influenced by societal regimes and serves as a key site for the exercise of power. This perspective challenges the belief that the body is governed solely by biological laws, emphasizing its role as a social and cultural artifact.

Foucault highlights that the body is central to disciplines like criminology, medicine, and sexology, which define how individuals experience themselves both as subjects and as objects. Our perception of the body shapes our sense of self while simultaneously linking us to others through shared characteristics such as race, gender, and age.

Foucault identifies two historical phases in how the body has been conceptualized and controlled.

1. **Anatomico-Metaphysical Register:** During the 16th and 17th centuries, sickness, insanity, and criminality were often treated as indistinguishable. Therapy involved physical punishment or interventions like bleeding and leeching to enforce obedience and conformity. Justice systems at the time focused on physically disciplining the body as a means of maintaining centralized power.
2. **Technico-Political Register:** In modern times, medicine and social institutions have shifted focus from punishment to rehabilitation. Institutions like hospitals, prisons, and asylums aim to regulate and rehabilitate individuals using scientific concepts of health and normality. The body is now shaped and disciplined through social structures, reflecting the internalization of these concepts and the growing influence of professional expertise in defining and managing “normal” bodies.

#### 2.4.3.1 The Body as a Site of Resistance

Foucault also acknowledges that the body, while being shaped by social, political, and economic structures, can become a site of resistance. Class, gender, and ethnicity influence how bodies are socially constructed often reflecting systems of domination. However, awareness of these constructs allows for alternative discourses and opportunities to challenge or reshape these influences. The evolution of technology and medicine has further transformed how the body is understood and treated. Bryan Turner distinguishes between foundationalist approaches, which treat the body as a fixed biological entity, and anti-foundationalist or social constructionist approaches, which view the body as a product of power and discourse. Modern imaging technologies and advancements in medicine have led to the emergence of “plastic” and “bionic” bodies, where surgical and technological interventions can alter or enhance physical characteristics. This shift has blurred the boundaries between natural and artificial, creating “hyper-real” bodies that are increasingly shaped by technology. Cosmetic surgeries, bionic implants, and designer organs are now commonplace, reflecting how bodies and identities are continuously reshaped by technological and economic forces.

◆ *Emerging sites of resistance*



#### 2.4.4 Ivan Illich: Medical Nemesis

##### ◆ Claims of modern medicine

Ivan Illich, in his *The Epidemics of Modern Medicine*, says the diseases and health patterns in Western societies have drastically changed over the last three generations. While infectious diseases like polio, tuberculosis, and diphtheria have declined, diseases associated with old age, such as coronary heart disease, cancer, and diabetes have risen. Interestingly, Illich argues that these shifts are not significantly linked to advancements in medical care. Instead, they are largely influenced by improvements in environmental and social conditions, such as better nutrition, housing, and sanitation. Illich critiques the belief in the effectiveness of modern medicine, suggesting that its role in reducing mortality rates is overstated. Historical data shows that the decline in infectious diseases often preceded the introduction of medical interventions like antibiotics and vaccines. For example, tuberculosis mortality rates were already decreasing before effective treatments were available, largely due to improved living standards.

##### ◆ New burdens

The phenomenon of *iatrogenesis*—diseases caused by medical interventions—has added a new burden to modern healthcare. While some medical technologies and practices, like smallpox vaccination and water sanitation, have had a positive impact, many treatments are costly, ineffective, or even harmful. Illich emphasizes that environmental factors and nonmedical health measures, rather than professional medical care, are the primary determinants of population health. Illich says that the perception of medical progress is often an illusion, driven by awe-inspiring technology and rhetoric. He calls for a reassessment of the role of medicine in society, advocating for a focus on environmental and cultural factors that genuinely improve health outcomes.

According to Ivan Illich, the concept of defenseless patients highlights the harmful effects of modern medical systems on individuals and society. Illich identifies three levels of iatrogenesis—negative consequences caused by medical intervention:

1. **Clinical Iatrogenesis:** This involves direct harm to patients from medical treatments, either due to mistakes, unnecessary interventions, or defensive practices by doctors aimed at avoiding litigation. Such practices can often cause more damage than the illnesses they seek to treat.

2. **Social Iatrogenesis:** Medicine reinforces a society that promotes dependence on curative and preventive interventions. This overmedicalization of life leads to the “expropriation of health,” where individuals lose their ability to manage health autonomously. Medically certified ailments remove individuals from the workplace and political activism, fostering a passive acceptance of illness and social conditions that perpetuate sickness.
3. **Cultural Iatrogenesis:** The deepest impact of medicine lies in its erosion of people’s capacity to confront suffering, vulnerability, and death in a personal and autonomous way. By adopting an engineering approach to health, medicine creates a culture of dependence on managed care, leading to prolonged states of suboptimal health rather than genuine well-being.

◆ *Negative impacts*

Illich terms the cumulative and self-perpetuating negative impact of medicine as medical nemesis. This phenomenon, rooted in hubris—human overreach and reliance on medical systems—resembles the Greek concept of divine retribution for exceeding natural limits. Illich argues that medical nemesis cannot be resolved through more medical interventions or bureaucratic solutions. Instead, it requires a fundamental shift: reclaiming the individual’s capacity for self-care and legally limiting the dominance of professional medical monopolies.

### 1. Political Transmission of Iatrogenic Disease

Illich introduces “social iatrogenesis,” which refers to the negative impact of medical institutions on overall societal health. This occurs when medical systems create dependency, reduce people’s tolerance for pain, and undermine self-care. Medical bureaucracy standardizes health care, institutionalizing suffering while eroding traditional practices of birth, sickness, and death within homes. This monopolization of health care transforms personal health issues into bureaucratic ones, discouraging individual autonomy and community-based care.

### 2. Medical Monopoly and Radical Monopolization

Illich argues that modern medicine has become a “radical monopoly,” where medical professionals dominate health care to the extent that individuals are rendered incapable of managing their own health. Similar to how cities devalue



walking by prioritizing vehicles, medical systems devalue mutual care by criminalizing self-treatment. This monopoly reinforces a society dependent on medical systems for addressing the health issues created by industrialized lifestyles, marginalizing those who deviate from societal norms.

### 3. The Role of Medicine in Defining Morality

Illich highlights the moral power of medicine, likening it to law and religion in its ability to define norms and label deviance. Physicians determine what constitutes illness, who is sick, and what treatments are necessary. This authority extends to labeling some pain as subjective, certain deaths as legitimate, and even societal complaints as medical conditions requiring treatment. Western medicine, which claims to be value-neutral, exerts significant control through scientific legitimacy, yet its interventions are deeply embedded in moral and political frameworks. Illich asserts that medicine's claim of being value-free is misleading and has enabled unchecked medical dominance. He calls for a critical, lay-led review of "social iatrogenesis" to address the political and societal harms caused by the medical system. Only by challenging the institutionalized taboos surrounding medical authority can society address the systemic issues that modern medicine perpetuates.

### 4. Medical Budget

According to Ivan Illich, the medicalization of the budget highlights the growing economic burden of health care on societies. In the United States, health care expenditures rose dramatically, increasing from less than a month's income per worker before 1950 to between five and seven weeks' earnings by the mid-1970s. By 1975, health care accounted for 8.4% of the U.S. Gross National Product (GNP), up from 4.5% in 1962, with costs escalating at a rate far exceeding inflation. Similar trends were observed globally, with industrial nations allocating an increasing share of their national budgets to health care. Illich notes that the rising costs are not solely attributable to physicians but also to the growth of medical bureaucracies and administrative expenses, which can account for a significant portion of health care spending. Additionally, high-cost hospital care and the prevalence of new, expensive technologies contribute substantially to these increases. For instance, the daily cost of hospital care in the U.S. rose by 500% since 1950, and hospital construction costs

◆ *Increase in budget*

have skyrocketed due to the rapid obsolescence of medical equipment.

◆ *Prepayment*

Illich critiques the system of prepayment through insurance, which incentivizes hospitals to offer costly services that patients may neither need nor demand. This self-reinforcing cycle of high-cost care disproportionately benefits health providers and administrators, further straining budgets. Similar patterns are evident in both capitalist and socialist nations, where health expenditures rise regardless of political ideology.

◆ *Unequal distribution*

In poorer countries, the medicalization of health budgets results in an unequal distribution of resources. Most public health funds are spent on curative care for individuals rather than preventive measures, such as sanitation, leaving the majority of citizens without access to basic health services. He argues that the medicalization of life has not correlated with improved health outcomes. For example, despite increased spending, life expectancy for adult males in the U.S. declined in the mid-20th century. He calls for a demedicalisation of health care, emphasizing cost-consciousness and reduced reliance on high-cost medical interventions.

#### **2.4.4.1 The Pharmaceutical Invasion**

◆ *Aggression of pharmaceuticals*

Illich argues that the medicalization of societies does not require an abundance of doctors, hospitals, or medical schools. Cultures are inherently tied to their own poisons, remedies, and rituals, but the introduction of powerful pharmaceutical drugs disrupts these traditional patterns, often causing more harm than good. This process transforms the perception of the human body into a mechanical system dependent on external manipulation. Illich highlights how pharmaceutical products, especially in poorer countries, have infiltrated markets through aggressive promotion and exploitation. For instance, drugs like chloramphenicol have been overprescribed and misused, leading to severe health consequences such as drug-resistant diseases and fatalities. Despite regulatory efforts in some countries, pharmaceutical firms often prioritize profits over patient safety, dumping outdated or dangerous drugs into less-regulated markets. In wealthier nations, overconsumption of prescription drugs is prevalent, driven by both doctors' and patients' increasing reliance on medicalized solutions for physical and psychological issues. Industries heavily promote drugs through advertising and influence over the medical

profession, often prioritizing profits over education or public health.

◆ *Belief in technology*

Illich critiques the broader cultural belief in technology and pharmaceuticals as solutions to health issues, arguing that this mindset drives overconsumption. This overreliance, he suggests, is tied to societies focused on endless consumerism, which fosters addiction to both medical and non-medical drugs. Blaming pharmaceutical companies alone is insufficient, as the problem stems from ideologies that prioritize technological interventions over traditional, community-based approaches to health care.

#### 2.4.4.2 Diagnostic Imperialism

◆ *Influence of physicians*

In a medicalized society, physicians wield significant influence, shaping not only healthcare but also social classifications. Medical certifications grant individuals specific statuses, often limiting their autonomy. For instance, doctors determine who can work, drive, or even live independently, and their authority extends to decisions about life and death. Historically, this began with mandatory medical certifications, such as those ensuring “fit” testimony under torture, and has since expanded into bureaucratic control over various life stages. Illich highlights how life has become increasingly medicalized, with each phase categorized as a “risk” requiring professional oversight. From birth to old age, individuals are conditioned within environments that define health narrowly, often fostering dependence on institutions like hospitals, which dominate modern landscapes as symbols of control and care. This medicalization reduces life to a “statistical span,” with individuals treated as patients rather than autonomous beings.

◆ *Over-complication*

He critiques how modern medicine often overcomplicates care for conditions that could improve naturally or with minimal intervention. For instance, many acute illnesses resolve on their own, yet excessive medical interventions undermine individuals’ ability to manage their health independently. Similarly, old age, traditionally seen as a natural phase of life, is now treated as a condition requiring professional services. This has led to the marginalization of the elderly, who are increasingly institutionalized, losing their independence and community connections. Illich points out that institutionalization often worsens health outcomes, with higher mortality rates among those removed from familiar surroundings.

### 2.4.4.3 Preventive Stigma

- ◆ *Rise of preventive medicine*

According to Ivan Illich, the rise of preventive medicine has led to the medicalization of health, transforming it from a personal responsibility into a managed commodity. Preventive care now focuses on identifying risks, turning healthy individuals into patients through routine check-ups and early diagnoses. You can observe that free check-ups on special occasions, such as Women's Day and Breast Cancer Awareness programs, along with diagnostic facilities, help this process. This process reflects a shift where health care becomes a status symbol, with high-ranking individuals receiving extensive maintenance care as a mark of their value. Illich critiques this trend as a symptom of social iatrogenesis, where medicine creates social harm by labeling individuals and perpetuating stigma. Diagnoses, whether temporary or permanent, assign social roles and can lead to irreversible stigmatization. Unlike curative care, preventive medicine often imposes lifelong labels, such as "former mental patient" or "carrier of genetic traits," isolating individuals and subjecting them to discrimination and unnecessary treatment.

- ◆ *Focus on illness*

He highlights the diagnostic bias in favor of sickness, driven by a medical culture that prioritizes identifying illness over confirming health. This bias often results in unnecessary or harmful interventions, such as routine surgeries or complex tests that offer little to no improvement in life expectancy. Furthermore, Illich emphasizes the dangers of diagnostic errors, aggressive medical interventions, and the stress imposed by routine testing, which can undermine autonomy and well-being.

### 2.4.4.4 Medicalization of Death

According to Ivan Illich, modern medical practices surrounding terminal care have ritualized death into an elaborate and expensive ceremony. Medical interventions at the end of life often blur the line between healing and death management, creating a space where physicians take on a priest-like role. This "terminal ceremony" prioritizes technical interventions over meaningful care, resulting in a disconnection between the dying individual and their autonomy. Illich argues that these medicalized rituals inflate the cost of dying, with resources disproportionately funneled into life-extension technologies that often provide little benefit. The focus on crisis management in hospitals removes

◆ *Medicalised rituals*

the need to prove the effectiveness of these interventions, granting medical professionals unchecked authority while diminishing the dignity of the dying process. Hospital deaths, which are increasingly prevalent, subject patients to isolation, indignity, and excessive medical procedures, while the belief in the necessity of hospitalization for pain relief or extended life often goes unexamined and unsupported by evidence.

◆ *Social fear*

This medicalization of death reflects social fears of “unhygienic” or unassisted dying. Historically rooted in the rejection of religious assistance, this fear has now become a universal anxiety, exacerbated by the commercialization of life-prolonging techniques. The public’s fascination with high-technology care sustains a “medical priesthood” that symbolically battles death, despite limited or even harmful outcomes for patients. Illich highlights how these practices alienate individuals from their natural ability to confront death, transforming it into a managed and commodified event rather than a personal or familial experience.

#### **2.4.4.5 Symbolic and Ritualistic Aspect of Medicine**

◆ *Symbolic role*

According to Ivan Illich, the functions of medical institutions extend far beyond technical interventions like curing diseases or removing pathogens. Historically, medicine has fulfilled religious, magical, ethical, and political roles. Illich suggests that even modern physicians, despite their focus on technical expertise, often play symbolic or ceremonial roles akin to magicians or priests. For instance, the placebo effect demonstrates how healing can depend on the psychological and ritualistic aspects of medicine rather than technical efficacy. Traditional medicine also included magic, where the healer’s manipulation of the environment and shared intent with the patient played a central role. Similarly, religious medicine offered frameworks for understanding suffering, emphasizing personal responsibility and providing cultural and spiritual support. In industrialized societies, however, secular institutions have largely taken over these roles, embedding myths of progress and technical salvation into medical practice.

## Summarised Overview

This unit has provided a critical exploration of medical discourse by engaging with the influential works of Michel Foucault and Ivan Illich. In *The Birth of the Clinic*, Foucault's analysis of the medical gaze showed how clinical spaces function as sites of observation, classification, and normalization, leading to the dehumanization of patients and the transformation of the body into an object of knowledge and control. His broader history of medicine reveals the shifts in how societies come to understand disease, the body, and care, and how these shifts are always tied to changing power structures.

The body, however, is not just a passive recipient of medical discourse—it is also a site of resistance. Foucault's work helps us see how people can challenge and subvert medical authority, even within systems that seem all-encompassing. This theme of resistance connects to Ivan Illich's radical critique of modern medicine in *Medical Nemesis*. He critiques the medical monopoly and warns against radical monopolization, where institutional medicine limits individual autonomy and community-based alternatives. Illich's insights into the moral authority assumed by medicine, the medicalization of budgets, and the pharmaceutical invasion offer a powerful lens for analyzing how medicine extends its reach into all aspects of life.

Moreover, Illich's ideas on diagnostic imperialism, preventive stigma, and the medicalization of death challenge learners to question how medicine shapes not only our health but also our identities, behaviors, and even our understanding of life and death. By critically engaging with these perspectives, students are encouraged to question the taken-for-granted authority of medical institutions and to recognize the broader social, political, and ethical implications of medical knowledge and practice in contemporary society.

## Self-Assessment Questions

1. Who is the author of *The Birth of the Clinic*?
2. What did Foucault mean by the term *anatomo-politics*?
3. What is meant by *clinical iatrogenesis*?
4. Briefly explain the concept of the *medicalisation of the budget*.
5. Explain Foucault's ideas on the body in relation to power and knowledge.
6. How does Foucault trace the history of medicine in his works?
7. Critically evaluate Ivan Illich's critique of modern medicine with relevant



examples.

8. Elucidate Foucault's concept of *medical discourse*, providing suitable examples.

## Assignments

1. Critically analyze Foucault's concepts of *anatomopolitics* and *biopolitics* in the context of modern healthcare systems.
2. Discuss the transformation of medical knowledge and the doctor-patient relationship across the three historical stages outlined in Foucault's *The Birth of the Clinic*. How does this transformation reflect broader shifts in power, discourse, and institutional authority?
3. Examine how the *technico-political* register of modern medicine disciplines and normalizes the human body through institutions like hospitals, prisons, and schools.?
4. Evaluate Ivan Illich's critique of modern medicine with reference to *clinical, social, and cultural iatrogenesis*. In what ways does Illich challenge the medical profession's role in constructing illness and dependency in modern societies?
5. How does medical discourse contribute to the social construction of morality and normality in society? Analyze this question through the lenses of *diagnostic imperialism, medicalization of budget, and the role of medicine in defining deviance*.

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## Space for Learner Engagement for Objective Questions

Learners are encouraged to develop objective questions based on the content in the paragraph as a sign of their comprehension of the content. The Learners may reflect on the recap bullets and relate their understanding with the narrative in order to frame objective questions from the given text. The University expects that 1 - 2 questions are developed for each paragraph. The space given below can be used for listing the questions.



SGOU

# Social Transformation: Different Forces

## **BLOCK-03**





# Folk Medicines and Traditional Healing Practices

## Learning Outcomes

On completion of the unit, the learner will be able to:

- ◆ examine folk medicines and traditional healing practices
- ◆ explore environmental hygiene and health practices
- ◆ analyse factors influencing health attitudes and behaviour

## Background

Health is a multidimensional concept influenced by cultural, environmental, and behavioural factors. Folk medicines and traditional healing practices are part of the rich heritage of Indigenous communities, offering insights into holistic approaches to health and wellness developed over the ages. It dwells on environmental hygiene and nutrition as part of public health, elaborating on the importance of a clean environment and appropriate dietary habits in preventing diseases and promoting general well-being. Health attitudes and behaviours, developing from socio-cultural norms and perceptions of individuals, become a crucial determinant of health outcomes.

## Keywords

Environmental hygiene, Nutrition, Health attitudes, Health behaviours, Public health

## Discussion

This unit will highlight the interconnected roles of traditional healing practices, environmental hygiene, nutrition, and health behaviours in shaping health outcomes. Folk medicines and traditional healing practices are also of great cultural and historical significance in that they offer

◆ *Promoting awareness*

holistic approaches that address individuals' physical, mental, and spiritual well-being. Such practices are often relied on in places with less access to modern health care. They emphasise the need to safeguard indigenous knowledge while integrating it into evidence-based healthcare systems. Environmental hygiene and nutrition are mighty pillars of public health in preventing infectious diseases and chronic illnesses. Health attitudes and behaviours underline the importance of promoting awareness of fostering sustainable health practices and are developed from cultural norms and individual perceptions.

### **3.1.1 Folk Medicines and Traditional Healing Practices**

◆ *Biomedicine*

Folk medicines and traditional healing practices in India represent a rich and diverse body of indigenous knowledge systems passed down through generations. These systems are deeply embedded in cultural, spiritual, and ecological contexts and serve as vital components of health care, particularly in rural, tribal, and underprivileged regions. They often use locally available herbs, animal products, minerals, and ritualistic techniques to address physical, psychological, and spiritual ailments. As highlighted by Charles Leslie in *Asian Medical Systems: A Comparative Study* (1980), such systems Ayurveda, Siddha, Unani, and tribal medicine are based on well-defined philosophies, differing fundamentally from biomedicine in their approaches to disease causation, diagnosis, and treatment.

◆ *Traditional medicine*

Sujatha and Abraham (2011) emphasise that traditional healing in India does not merely act as an "alternative" to biomedicine but forms part of a larger system of medical pluralism, where individuals access multiple systems according to their illness experience, belief systems, and socio-economic realities. This pluralism reflects historical continuity and contextual relevance, particularly in a country as diverse as India.

◆ *Oral transmission*

Traditional medicine in India includes codified systems like Ayurveda, Unani, and Siddha, as well as folk and tribal healing traditions. These systems rely on ancient texts, oral transmission, and centuries of observation and practice. India has institutionalised these practices through the Ministry of AYUSH, which promotes and regulates these systems nationally.



- ◆ Ayurveda is based on balancing the three doshas – Vata, Pitta, and Kapha – using herbal formulations, panchakarma (detoxification), yoga, and diet.
- ◆ Unani medicine, with roots in Greco-Arabic tradition, emphasises balance among the four humours (blood, phlegm, yellow bile, black bile), using techniques like Hijama (cupping), massage, and herbal prescriptions.
- ◆ Siddha medicine, practiced predominantly in Tamil Nadu, emphasises rejuvenation through herbs, minerals, and alchemical substances.

◆ *Lifestyle changes*

Sujatha (2011) notes that Siddha medicine incorporates astrology, diet, and ritual into its treatment, making it highly culturally embedded. Similarly, Seema Alavi (2007) and Gail Omvedt have studied the evolution of Unani medicine in colonial and post-colonial India, highlighting its adaptability and its role in shaping Muslim identity and resistance to colonial medical dominance.

Many traditional systems emphasise that health is not merely the absence of disease but a state of balance between body, mind, spirit, and environment. Thus, lifestyle changes are essential to disease prevention and healing.

◆ *Holistic Approach*

- ◆ Ayurveda promotes Dinacharya (daily routine) and Ritucharya (seasonal regimen) to maintain doshic balance.
- ◆ Siddha and Naturopathy recommend dietary regulations, fasting, and the integration of yoga and meditation.
- ◆ Unani systems encourage moderation in eating, sleeping, and physical activity based on the individual's temperament (mizaj).

◆ *Healing systems*

These lifestyle prescriptions offer preventive care that is culturally familiar and economically sustainable attributes highly valued in resource-limited settings in India. Traditional healing systems offer a holistic approach to health. As described in *Paths to Asian Medical Knowledge* (Leslie & Young, 1992), healing involves not just the body, but also the psyche, spirit, and social relations.

This is particularly evident in tribal and folk healing practices, where treatments are combined with rituals, chants, spiritual ceremonies, and the use of sacred plants. Healing becomes a community process involving elders, family members, and local shamans or healers.

◆ *Medieval Period*

Harish Naraindas, Johannes Quack, and William Sax (2014), in *Asymmetrical Conversations*, observe that these indigenous systems do not simply exist in isolation or opposition to biomedicine but engage in mutual, though unequal, exchanges. These “asymmetrical” engagements result in knowledge hybridity and patient-led choices.

◆ *Rural areas*

India’s tribal and indigenous medicine is a valuable repository of local knowledge, especially prevalent in rural and forested areas. Tribal healers rely on herbs, roots, and tree barks sourced from their natural surroundings to treat various illnesses. These treatments are often accompanied by ritual healing, including chanting and spiritual ceremonies, which are believed to enhance the healing process.

For example:

- ◆ The bark of the Arjun tree is commonly used for heart-related health issues.
- ◆ Tulsi (holy basil) leaves are used as remedies for fever and colds.

In many Indian households, traditional home remedies are part of everyday health care. Common practices include:

- ◆ Drinking ginger tea to relieve colds
- ◆ Applying turmeric paste on wounds to prevent infection,
- ◆ Using fenugreek for digestion problems
- ◆ Steam inhalation with eucalyptus for respiratory relief,
- ◆ Massages with oils such as castor or sesame to ease joint pain.

◆ *Lifestyle changes*

Another widely practiced system is Naturopathy, which focuses on natural remedies and lifestyle changes. It includes treatments such as mud baths, hydrotherapy, and yoga to restore health. Remedies like neem leaves for detoxification and amla juice for boosting immunity emphasise a reliance on natural resources and holistic living.



◆ *Traditional architecture*

Spiritual and energy-based healing also plays an important role in Indian folk medicine. Practices such as Vaastu (traditional architecture and energy balance) and mantra chanting are used to cleanse spaces and individuals of negative energies. Sacred plants like holy basil are believed to ward off evil vibrations and improve emotional and mental well-being.

◆ *Rural and Forested*

Traditional bone-setting is a common form of rural orthopaedics in India. Healers treat fractures and sprains by manually adjusting bones and applying herbal pastes and oils to reduce swelling and pain. Overall, the Indian subcontinent hosts diverse folk medicine systems that address physical, mental, and spiritual health. This traditional knowledge continues to be vibrant and widely practised, particularly in rural and underserved communities.

### **3.1.2 Environmental Hygiene and Health Nutrition**

◆ *Healthy environment*

Environmental hygiene refers to the practices and conditions that help maintain a clean and to prevent the spread of diseases and promote overall well-being. It involves managing and controlling factors in the environment such as air, water, food, waste, and living conditions that can affect human health. Good environmental hygiene includes proper sanitation, waste disposal, a clean water supply, vector control (like mosquitoes and rodents), and maintaining clean surroundings in homes, workplaces, and public areas. By minimising exposure to harmful agents and contaminants, environmental hygiene plays a crucial role in preventing infections and supporting a healthy community.

#### **1. Health Nutrition**

◆ *Balanced diet*

Health nutrition is the science and practice of consuming and utilising food in ways that promote good health, growth, and well-being. It involves eating a balanced diet that provides essential nutrients such as carbohydrates, proteins, fats, vitamins, and minerals in appropriate amounts to meet the body's needs. Proper nutrition supports bodily functions, strengthens the immune system, prevents nutritional deficiencies, and reduces the risk of chronic diseases like diabetes, heart disease, and obesity. Health nutrition also includes educating individuals and communities about healthy eating habits and dietary choices to maintain optimal health throughout life.

◆ *Collective behaviour*

From a sociological perspective, environmental hygiene and health nutrition are closely interconnected elements of public health that reflect broader social structures, collective behaviours, and systemic inequalities. Both depend not only on individual choices but also on the social environment and institutional frameworks that shape access to resources and information.

◆ *Good health*

Environmental hygiene directly impacts health nutrition because unsanitary conditions such as contaminated water, poor waste disposal, and inadequate sanitation increase the risk of infections like diarrhoea and parasitic diseases, which in turn impair nutrient absorption and overall nutritional status. For example, children living in areas with poor environmental hygiene often suffer from repeated bouts of diarrhoea, leading to malnutrition and stunted growth. Thus, without proper environmental hygiene, even adequate food intake may not translate into good health.

**Examples:**

- ◆ In rural India, lack of access to clean drinking water and toilets leads to open defecation, resulting in waterborne diseases that undermine the nutritional status of vulnerable groups (Bhan et al., 2019).
- ◆ Urban slums worldwide face overcrowding and poor waste management, causing environmental contamination that exacerbates malnutrition among children due to recurrent infections (Ezeh et al., 2017).

### 3.1.2.1 Social Embeddedness of Environmental Hygiene

◆ *Improve hygiene*

Environmental hygiene is embedded in social organisations and shaped by communal efforts, government policies, and cultural norms. For instance, community-led sanitation programmes such as India's Swachh Bharat Mission rely on collective participation and behavioural change to improve hygiene. However, marginalised groups often face systemic barriers like lack of political voice or economic resources that prevent equitable access to sanitation facilities.

**Examples of sociological studies**

- ◆ Studies by Wilkinson and Marmot (2003) highlight how socio-economic inequalities translate

into health disparities through environmental determinants like housing quality and sanitation access.

◆ *Social Institutions*

- ◆ Research in urban slums of Nairobi by Amedzi et al. (2018) shows how social neglect and infrastructural deficits create unhygienic environments that perpetuate cycles of poor nutrition and disease.

Overall, sociologists emphasise that improving environmental hygiene and health nutrition requires addressing structural inequalities and strengthening social institutions responsible for health governance, ensuring inclusive and sustainable public health interventions.

◆ *Nourished Population*

On the other hand, health nutrition is influenced by social determinants such as income, education, and food availability. Nutritional deficiencies are frequently tied to socioeconomic status, with lower-income groups facing higher risks of malnutrition due to limited access to diverse and nutritious foods. Food deserts—areas where healthy food options are scarce—highlight systemic inequalities in health access. Sociological theories, including conflict theory, underscore how power dynamics in food production and distribution affect health outcomes, while structural functionalism suggests that a well-nourished population enhances societal stability by reducing disease burdens.

◆ *Collective action*

Environmental hygiene promotion requires collective action, often driven by social movements and policy interventions. Community-driven sanitation initiatives, such as waste management programmes and hygiene awareness campaigns, exemplify the importance of social cohesion in health improvements. Schools and workplaces are crucial in reinforcing hygiene norms and instilling behavioural practices that extend beyond individual responsibility to structural reforms. The interplay between environmental hygiene and health nutrition forms a cycle of well-being, necessitating systemic changes in urban planning, food policies, and public health infrastructure to create a healthier society.

Environmental degradation and pollution significantly affect health nutrition in India by compromising essential resources like air, water, and soil, which are critical for producing safe and nutritious food. Air pollution, especially in urban and industrial areas, increases respiratory illnesses and

◆ *Essential resources*

weakens immune systems, leading to poor nutrient absorption and higher rates of child malnutrition, including stunting and wasting (Global Burden of Disease, 2019). Contaminated water sources – affected by industrial waste, pesticides, and heavy metals such as arsenic – cause waterborne diseases that impair digestion and nutrient uptake; according to NFHS-5 (2019-21), about 17% of households rely on unsafe drinking water, exacerbating malnutrition risks among children.

◆ *Nutritional status*

Soil degradation from overuse of chemical fertilisers reduces crop micronutrient content, contributing to widespread deficiencies like iron-deficiency anaemia, affecting over half of Indian children under five (Poshan Abhiyaan, 2020). Additionally, the Ministry of Environment reported that nearly 60% of India's groundwater is polluted, further threatening food safety and nutritional health. UNICEF (2018) found that children living in polluted areas face a 20% higher risk of stunting compared to those in cleaner environments. Thus, environmental pollution directly and indirectly undermines nutritional status in India, especially among vulnerable populations, highlighting the urgent need for integrated environmental and public health interventions.

◆ *Various life Stages*

Health nutrition refers to the intake of food in adequate quantity and quality to maintain health and support growth. According to the World Health Organization (WHO), nutrition is “the intake of food, considered in relation to the body's dietary needs.” Key indicators include stunting, wasting, underweight, and micronutrient deficiencies. Globally, malnutrition remains a major public health issue, with millions affected by both undernutrition and obesity. In India, including Kerala, despite progress, significant health inequalities persist. Women and marginalised groups suffer higher rates of anaemia, undernutrition, and micronutrient deficiencies due to poverty, social exclusion, and limited access to healthcare. To improve health nutrition, strategies such as enhancing food security, promoting maternal education, ensuring access to clean water, and strengthening public health nutrition programmes are essential.

◆ *Promoting health*

Health nutrition is basically for the promotion of health and the prevention of disease. It refers to proper nutrition intake that would supply the body with the right amount of carbohydrates, proteins, fats, vitamins, and minerals. Proper nutrition supports various body functions, including energy production, growth, repair, and immunity.

◆ *Sustainable development*

In light of the highly dynamically changing health challenge-like situation brought about by COVID-19, this becomes highly relevant, showing the underlying value of nutrition in enhancing recovery and resistance. Health nutrition can be promoted on many levels: education, policy, and community engagement. The advantages of healthy nutrition are subjects to be pointed out during public health campaigns, while food fortification and subsidies for healthy food make nutrition accessible for everyone. Encouraging sustainable agriculture will provide a steady supply of nutritious foods. A healthy nutritional culture, if cultivated, would improve the quality of life of societies, reduce disease burdens, and contribute to sustainable development.

◆ *Inadequate facilities*

## 2) Factors Affecting Environmental Hygiene

The availability of sanitation facilities, clean water, waste management systems, and general environmental conditions determines the environment's hygiene. A significant determinant of health is access to sanitation and clean water, as inadequate facilities cause the proliferation of waterborne diseases like cholera and typhoid, mainly in areas like rural and urban slums with poor infrastructure. The other most important factor is the efficiency of waste management systems. Poorly managed waste may pollute, provide breeding sites for disease vectors like mosquitoes, and contaminate water. Besides, air pollution from industrial emissions, vehicle exhaust, and the burning of waste directly impacts respiratory health and causes environmental degradation. Community awareness and practices also play a critical role in maintaining hygiene. Low awareness of basic hygiene practices, such as hand washing or waste segregation, may go a long way in compromising community health. This often concerns government policies and interventions that worsen these conditions if not well done or enforced.

◆ *Sanitation facilities*

Environmental hygiene is influenced by various social, economic, and institutional factors that sociologists study to understand public health disparities. Studies show that poverty is a major determinant, as low-income communities often lack access to clean water and proper sanitation facilities (Jain & Singh, 2019). Urbanisation and overcrowding also contribute to poor environmental hygiene by increasing waste generation and straining municipal services (Sharma et al., 2021). Additionally, social norms and cultural practices impact hygiene behaviours; for example, community attitudes towards waste disposal and water use vary across

regions (Kumar & Bhattacharya, 2020). Governance and policy implementation play a critical role, where weak infrastructure and inadequate government oversight exacerbate hygiene challenges in marginalised areas (Patel & Mehta, 2018). These factors collectively shape the uneven distribution of environmental hygiene conditions in society.

### 3) Factors Influencing Health Nutrition

Socio-economic, cultural, and biological factors influence health nutrition. A significant determinant of this is socioeconomic status; those in the lower-income category face a barrier to nutrient-dense food products due to an issue of affordability. This is further compounded by food availability and accessibility in remote areas, whether rural or within urban food deserts, which are likely to have limited access to fresh produce. Cultural and dietary practices also shape nutrition. While traditional diets may emphasise whole foods, some practices can result in inadequate nutrition. For instance, cultural taboos or preferences may limit the intake of specific nutrient-dense foods.

- ◆ *Traditional Diet*

### 4) Interrelated Factors

Environmental hygiene and health nutrition go hand in hand. For example, the intake of polluted water and poor sanitation can lead to gastrointestinal diseases that will cause malnutrition by impairing nutrient absorption. In the same breath, environmental factors like climate change will affect food production, reducing the availability and quality of nutritious foods. A healthy state of infrastructure also bridges the two domains, from access to clean healthcare facilities that prevent diseases from hygiene to nutritional programmes in schools and communities, ensuring everyone gets enough nutrients, especially for vulnerable populations like children and the elderly.

- ◆ *Vulnerable Population*

According to NFHS-5 (2019–21), only 58.6% of rural households in India have access to improved sanitation, illustrating the significance of indigenous hygiene solutions in areas lacking infrastructure. Nutritional indicators are equally concerning: 35.5% of children under five are stunted, and 32.1% are underweight. These figures underscore the need to examine how traditional food habits, often shaped by environmental realities, can complement efforts to combat malnutrition. Moreover, NSSO 75th Round data (2017–18) reveals that over 33% of rural households depend on non-allopathic systems like Ayurveda, Siddha, or local folk

- ◆ *Traditional food habits*



practices, highlighting the embeddedness of traditional knowledge in health behaviour where modern biomedical systems remain inadequate or culturally alienating.

### 3.1.2 Health Attitudes and Behaviour

#### ◆ *Regular routine*

Health attitude refers to individuals' attitudes towards their health, including health-risk and health-promoting attitudes. Health attitude is perceptions, beliefs, and values regarding good health care.

#### ◆ *Improve Health*

Health behaviours refer to activities people do to restore or improve their health. Positive attitudes toward health, therefore, translate into proactive behaviour in terms of regular exercise, nutritional eating, and adhering to medical advice. However, negative attitudes, such as lack of awareness, lead to harmful behaviours through non-observance of prevention or risky behaviours. Several factors influence health attitude formation, including cultural expectations, family influence, education, and personal experiences. For instance, individuals growing up in communities where exercise and healthy diets are stressed are more likely to develop positive attitudes toward the same behaviours. Health campaigns and education programmes also play an essential role in changing people's attitudes, such as vaccination promotion or the discouragement of smoking. Various health practices have cultural stigma and misinformation that act as a deterrent toward the development of healthy attitudes.

#### ◆ *Preventive Behaviour*

Health behaviour is usually categorised into two types: preventive and risk behaviours. Preventive behaviours include periodic health check-ups, vaccinations, and a healthy lifestyle to avoid contracting various diseases. On the other hand, risk behaviours are activities that boost the chances of adverse health conditions; these include smoking, excessive intake of alcohol, and leading a sedentary lifestyle. The gap between knowing and doing is critical since awareness alone is inadequate for healthy behaviour.

#### ◆ *Interaction of Health*

This interaction of health attitudes and behaviour can be explicitly viewed within the context of managing chronic diseases. For example, individuals with favourable views of their illness and treatment are likelier to adhere to medication regimens, dietary changes, and exercises. Individuals with negative health attitudes, such as denial or fatalism, may postpone care or not adhere to medical advice. Behavioural interventions include counselling and motivational strategies to help the individual develop a healthier outlook and improve treatment adherence.

- ◆ *Reduce Healthcare cost*

Developing positive health attitudes and behaviours is complex and demands proper education, integrative community support, and accessible healthcare services. Healthier attitudes might improve with publicly guided campaigns that overcome cultural hindrances and demolish misinformation. Also, enabling people with proper education and skills allows them to make appropriate decisions. By nurturing proactive health management, societies can achieve better well-being, reduce healthcare costs, and live a better quality of life.

### 3.1.2.1 Factors Influencing Health Attitudes and Behaviour

A dynamic interplay of multiple forces influences health attitudes and behaviours. These may range from individual beliefs and social influence to environmental conditions and access to healthcare. Understanding these influences is important in promoting healthy behaviours to bring about an improved state of public health outcomes.

#### 1. Socio-Cultural Factors

- ◆ *Cultural Norms*

The socio-cultural dimension is probably imperative in formulating health attitudes and behaviours. Cultural norms, traditions, and values strongly influence how people perceive health, illness, and healthcare practices. For instance, consulting a physician for minor complaints in many cultures is considered unnecessary; on the other hand, many others have wholeheartedly adopted preventive health practices such as yoga and meditation. The social environment created by family, friends, and community also affects health behaviours, such as what to eat, exercise, or smoke. Religious beliefs and practices also shape health attitudes. Some religions focus on practices such as fasting, vegetarianism, or specific dietary restrictions, all of which influence behaviours related to health.

#### 2. Economic Factors

- ◆ *Medical care*

Economic status is a significant factor in determining health attitudes and behaviour. People with higher incomes generally enjoy greater access to better health care, healthy food options, and other resources related to health, such as gyms or fitness programmes. On the other hand, lower-income individuals may have barriers to health, including

food insecurity, lack of access to quality healthcare, and no time or resources for physical activity. Financial constraints might also lead to unhealthy coping mechanisms, such as the consumption of inexpensive, calorie dense foods or reliance on harmful substances like alcohol or tobacco. Also, access to health insurance, regarding affordability and availability, can influence how people seek medical care and result in health attitude differences due to differences in economic stability.

### 3. Education and Awareness

Education is one of the most potent determinants of health attitudes and behaviours. People with higher levels of education are more likely to engage in health-promoting behaviours such as regular physical activity, healthy eating, and preventive health measures. This is because education helps people understand the link between lifestyle choices and health outcomes. Health knowledge, awareness of health risks, the benefits of a healthy lifestyle, and access to credible health information all shape health behaviours. For instance, those who are aware of the health hazards of smoking either avoid or try to quit the habit. Otherwise, misinformation or lack of access to proper health education may cause destructive behaviours or poor health choices.

#### ◆ *Lifestyle Choices*

### 4. Psychological and Emotional Factors

Psychosocial factors, including personality, mental health, and emotional well-being, play an influential role in forming healthy attitudes and behaviours. Individuals who experience high levels of stress or suffer from a mental health issue such as depression or anxiety may turn to maladaptive behaviours like substance abuse, overeating, or not getting exercise. On the other hand, good mental health and positive emotional well-being may encourage a person to have healthy lifestyle habits. For example, an individual with greater self-esteem, good resilience levels, and much more self-efficacy would readily take necessary positive actions regarding one's health.

#### ◆ *Personality Development*

### 5. Environmental and Physical Factors

The physical environment in which an individual resides can significantly impact health behaviours. The urban or rural setting, availability of parks or recreational spaces, access to public transportation, and general living conditions

◆ *Active opportunity*

determine a person's opportunity to be active, eat healthily, or avoid environmental health risks. For example, people living in an area with poor air quality or difficulty accessing fresh fruits and vegetables are more prone to unhealthy behaviours and poor physical health. On the other hand, built environments with safe walking paths and fitness centres are most likely to reinforce active living and healthful behaviour.

## 6. Social and Peer Influences

◆ *Social network influencing*

Peer pressure and social networks can influence an individual's health. Social groups or communities may encourage healthy behaviours, such as exercising together or preparing nutritious meals. On the other hand, peers may encourage unhealthy habits, like smoking or binge drinking, especially during adolescence or early adulthood. Another major factor in the formation of health attitudes is social support systems. Encouragement from family, friends, or co-workers may motivate people to adopt better health behaviours, for example, quitting smoking or starting a regular exercise programme.

## 7. Healthcare System Access

◆ *Professional Guidance*

Health attitudes and behaviours are also influenced by access to health services and quality health care. People in areas where health services are few or hard to reach are likely to delay seeking health counsel or may not follow through with the health advice provided. On the contrary, people with access to regular check-ups, preventive care, and health resources are likelier to show initiative in maintaining their health. The availability of health insurance, medical facilities, and professional guidance often encourages individuals to take a more active role in managing their health.

## 8. Media and Technology

◆ *Shapes Public Perceptions*

Information that media relays significantly influences attitudes and behaviours that contribute significantly to health. It shapes public perceptions of health and wellness through television, social media, advertisements, and health campaigns. Positive health messages, such as those on healthy eating, exercise, and mental health, may portend a good life for everyone; however, negative depictions of unachievable body images and destructive behaviour are quite self-defeating.



Figure 3.1.1 Media and Technology

## 9. Health Campaigns and Public Service Announcements

Traditional media outlets like television, radio, and newspapers have long been used for health campaigns to raise awareness about specific issues such as smoking cessation, vaccination, and mental health. For example, the anti-smoking campaigns in the U.S. have significantly contributed to reduced smoking rates over the decades. Public Service Announcements use emotional appeals, health facts, and expert endorsements to facilitate behaviour change, hoping audiences will live healthier lifestyles. Traditional media sources remain very influential, especially for older audiences or those with limited contact with digital technologies.

- ◆ *Digital Technologies*

## 10. Social Media and Health Information

The primary social media platforms are Facebook, Instagram, Twitter, and YouTube. These networking sites have also become primary conduits for disseminating health information. These platforms have made it easy for health organisations, influencers, and individuals to share tips, personal experiences, and expert advice regarding various health concerns.

- ◆ *Networking sites*

## 11. Health Education via Digital Media

Digital media through platforms like websites, blogs, and YouTube has emerged as a significant medium for disseminating health education. Health organisations

◆ *Emotional support*

and professionals use these channels to share tutorials, informational videos, and articles that empower individuals to make informed health decisions. These digital spaces are particularly valuable for individuals dealing with chronic illnesses or mental health conditions, fostering a sense of community and emotional support otherwise lacking in traditional clinical settings.

◆ *Moral duties*

Religious traditions often include teachings related to health, hygiene, and dietary practices, shaping everyday health behaviours across communities. These teachings are not merely spiritual but have significant implications for public health and lifestyle. Such religious prescriptions are often internalised as moral duties, guiding health-related choices. As discussed by Broom and Doron (2011) in *Health, Culture and Religion in South Asia*, religious norms play a crucial role in shaping how individuals understand illness, healing, and bodily care in culturally embedded ways. In this view, health is not simply a biomedical concern but also a moral and spiritual matter, deeply woven into the cultural fabric of South Asian societies.

◆ *Individual attitudes*

According to NFHS-5 (2019-21), only 58.7% of women aged 15-49 in rural India received four or more antenatal check-ups, revealing persistent gaps in formal maternal healthcare utilisation. Many still rely on dais (traditional birth attendants), perceived as empathetic, experienced, and culturally aligned.

Further, NSSO 71st Round (2014) data shows that over 17% of households in India continue to depend primarily on indigenous or traditional medicine systems. This reflects not resistance to modern medicine but an embedded belief in pluralistic health cultures where folk, spiritual, and biomedical systems coexist and are chosen based on accessibility, trust, and cultural fit.

## Summarised Overview

This unit explores the interaction between folk medicines and traditional healing practices embedded in the cultural heritage and indigenous knowledge systems. These practices, often passed from generation to generation, emphasise using natural remedies such as herbs, minerals, and rituals to address physical and mental ailments. In India, systems such as Ayurveda, Siddha, and Unani deal with the equilibrium of the body, mind, and environment to attain holistic health. Similarly, traditional tribal medicine plays an important role in rural health as an easily accessible, low-cost alternative to modern medicine. While advances in medical science are significant, such practices remain important because they are culturally accepted, accessible, and sometimes more effective in particular contexts.

Environmental hygiene and health nutrition are in the public health domain. Proper waste disposal, excreta disposal, and pollution control measures reduce the burden of infectious diseases. Equally important is health nutrition, ensuring the diet is balanced with all essential nutrients to support immunity and general well-being. Such factors as socio-economic status, education, and resource availability greatly influence these. Cleaner environments and proper nutrition are foundations for healthier communities, pointing out the integrated approaches in hygiene and dietary practices.

## Self-Assessment Questions

1. What elements play a role in shaping how individuals perceive and act towards health?
2. Explain the factors influencing health attitudes and behaviour.
3. How does environmental hygiene impact community health outcomes, particularly in rural India?
4. Discuss the role of traditional healing systems in shaping health-seeking behaviour in India.
5. In what ways does a digital medium influence health education and awareness in marginalised communities?

## Assignments

1. Examine how traditional remedies and ancient healing practices influenced modern approaches to health and well-being.
2. Explain the relationship between dietary patterns and the prevalence of lifestyle-related diseases.
3. Discuss how traditional health practices are integrated into contemporary healthcare systems.
4. Analyse how cultural values and traditions shape perceptions and approaches to health and wellness.
5. To what extent do governmental policies and programmes address disparities in sanitation and nutritional standards?

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### Space for Learner Engagement for Objective Questions

Learners are encouraged to develop objective questions based on the content in the paragraph as a sign of their comprehension of the content. The Learners may reflect on the recap bullets and relate their understanding with the narrative in order to frame objective questions from the given text. The University expects that 1 - 2 questions are developed for each paragraph. The space given below can be used for listing the questions.

SGOU



## Social Aspects of Acute and Chronic Lifestyle Diseases

### Learning Outcomes

On completion of the unit, the learner will be able to:

- ◆ analyse the social dimensions of diseases
- ◆ explore the societal consequences of diseases, including stigma, discrimination, and the importance of community
- ◆ evaluate the role of social behaviours, communication, and public health interventions in managing infectious diseases.

### Background

The social dimensions of acute and chronic lifestyle diseases, such as HIV/AIDS, and the broader social dimensions of pandemic diseases bring into light the complex relationship that exists between health, behaviour, and society. Diseases that have been linked to lifestyle factors, such as diet, physical inactivity, and stress, are becoming more prevalent in modern societies and are contributing to a great deal of morbidity and mortality. HIV/AIDS is a chronic infectious disease that, apart from being a severe health challenge, has significant social implications, including stigma and socio-economic disruption. Similarly, throughout history, pandemics have transformed societies, revealed the weaknesses of health systems, caused social disparities, and changed cultural practices. Such phenomena can only be understood with a multidisciplinary approach that views medical, sociological, and public health perspectives, emphasising community solidarity, awareness, and access to equitable healthcare.

### Keywords

Acute diseases, Chronic diseases, Lifestyle diseases, Social determinants of health, Healthcare access, Health inequalities



## Discussion

### ◆ *Social perspective*

The discussion shows that health challenges related to the social dimensions of acute and chronic lifestyle diseases, including HIV/AIDS and pandemic diseases, have to be met from a social perspective. Chronic lifestyle diseases are influenced by urbanisation, socio-economic disparities, and evolving cultural practices that require community-based interventions and preventive strategies. HIV/AIDS has been a case study in the way health issues dovetail with stigma, education, and policy, showing that there needs to be inclusive health systems and public sensitisation. Pandemic diseases further put a spotlight on the cross-linkages between societies around the world and expose inequities in access to healthcare, the role of misinformation, and effective health communication. The process of mitigating these diseases and fostering resilience in societies will be important in the collaborative efforts involving public health measures, cultural sensitivity, and community engagement.

### ◆ *Public health*

The term “acute lifestyle diseases” is conceptually inaccurate. Acute diseases refer to conditions that have a sudden onset and short duration such as infections, injuries, or asthma attacks. In contrast, lifestyle diseases are typically chronic in nature, meaning they develop gradually over time and persist for long periods. These are primarily influenced by behavioural and environmental factors, including unhealthy diet, physical inactivity, tobacco use, and prolonged stress. Therefore, the more accurate term is “chronic lifestyle diseases”, which includes conditions such as type 2 diabetes, cardiovascular diseases, hypertension, and obesity. Understanding this distinction is crucial in both medical and sociological discussions of public health.

### **3.2.1 Social Aspects of Acute and Chronic Lifestyle Diseases**

### ◆ *Chronic Lifestyle*

Acute and chronic lifestyle diseases like diabetes, hypertension, obesity, and heart disease have a significant impact on families and society. The development of these conditions places an emotional and economic burden on families due to caregiving, medication, and hospital visits. Acute complications like heart attacks and strokes can result in instantaneous disruption of family processes, with sometimes long-term consequences for the households concerned. In addition, they affect the workforce’s

productivity and put pressure on the health systems of communities where the diseases are prevalent. Social networks thus play a decisive role in managing this group of diseases, as peer support and community engagement foster healthier lifestyle choices. Lifestyle diseases are those highly related to social determinants of health, such as income, education, and access to healthcare.

### **a.Diseases**

Most marginalised populations bear higher risks due to inequities in the use of nutritious food, safe environments for physical activities, or even preventive healthcare services. For instance, urbanisation and a sedentary lifestyle more characteristically affect low-income groups in urban slums because of the availability of unhealthy food and lack of places for exercise. Chronic diseases can perpetuate cycles of poverty, as individuals may lose income due to reduced work capacity or high medical expenses, further exacerbating social inequities. Social and cultural norms influence behaviours that add to lifestyle diseases, including dietary habits, physical activity, and substance use. In some cultures, high-calorie foods or those containing a lot of sugar or fat may be associated with celebrations or hospitality. Similarly, social acceptance of smoking, alcohol consumption, or sedentary activities like screen time increases risks. Education and awareness efforts carried out in cultural contexts can enable behaviour change. Peer influence and social media also mould perceptions of health and wellness, making positive role models and accessible health information more imperative.

◆ *Marginalised*

### **b.Populations**

Chronic pain is a significant health issue that extends beyond its physical effects, influencing various aspects of social functioning in India. Unlike temporary pain caused by injury or illness, chronic pain persists for months or even years, often leading to physical limitations, mental health struggles, and social stigma. In India, where healthcare accessibility and cultural attitudes towards pain vary widely, individuals experiencing chronic pain often face unique challenges shaped by gender roles, economic conditions, and social hierarchies.

◆ *Chronic pain*

Cultural norms in India play a crucial role in how chronic pain is perceived and managed. Pain is often seen as a test of endurance rather than a condition requiring treatment. Traditional beliefs often associate suffering with fate or

◆ *Traditional beliefs*



spiritual growth, discouraging individuals from seeking medical intervention. This mindset leads to delayed diagnoses and treatment, making chronic pain a **silent burden** for many affected individuals. Additionally, a lack of awareness and structured pain management programmes contributes to the normalization of chronic pain, particularly in rural communities where medical infrastructure is inadequate.

### c. Stigma

#### ◆ Social stigma

Gender dynamics significantly impact how chronic pain is experienced and treated in India. Women, especially those engaged in domestic labour and caregiving roles, often suffer from chronic pain conditions such as arthritis, migraines, and lower back pain. However, their pain is frequently dismissed or attributed to emotional distress rather than physical ailments. The **gender pain gap** reflects broader healthcare inequalities, where women's symptoms are overlooked or underdiagnosed due to biased medical perceptions. Furthermore, societal expectations regarding family responsibilities often force women to prioritise caregiving over their health, worsening their conditions over time.

### d. Responsibilities

#### ◆ Employment

Economic disparities further complicate chronic pain management, as lower-income groups often struggle with access to proper treatment. High costs of specialised pain management therapies, medications, and rehabilitation services limit the options available to economically disadvantaged individuals. Employment challenges also arise, as workers suffering from chronic pain may experience reduced productivity or job insecurity, reinforcing cycles of poverty and inadequate healthcare. In contrast, wealthier individuals have access to better medical care, demonstrating how power structures influence health outcomes in Indian society.

### e. Challenges

#### ◆ Social awareness

Chronic pain in India requires comprehensive healthcare reforms, policy interventions, and social awareness programmes. Recognising chronic pain as a legitimate health concern, improving access to pain management clinics, and integrating mental health support into treatment strategies are essential steps toward improving the quality of life for affected individuals. Public awareness campaigns can help reduce stigma, encouraging people to seek medical help rather than endure silent suffering. Additionally, gender-

sensitive healthcare policies and workplace accommodations can support equitable pain management across different social groups.

### 3.2.1.1 HIV/AIDS

◆ *Psychological*

HIV is not merely a medical condition; it represents a complex social issue shaped by stigma, inequality, and healthcare accessibility. From a sociological perspective, Erving Goffman's (1963) concept of social stigma helps explain how individuals with "discredited" attributes such as HIV-positive status are often marginalised. Goffman noted that such stigma leads to "spoiled identities," where individuals are socially devalued. In the case of HIV, the illness is frequently associated with negative stereotypes related to sexuality, morality, and drug use. Labelling theory further elucidates how society assigns deviant labels to those with stigmatized conditions, reinforcing exclusion and shaping self-identity. This dual process of stigma and labelling results in widespread discrimination, discouraging people from seeking testing and treatment. Socioeconomic conditions also play a crucial role in the spread and management of HIV. Lower-income communities often struggle with inadequate healthcare infrastructure, making it difficult for individuals to access life-saving antiretroviral treatment. This disparity highlights broader social inequalities, as people with financial resources can afford better medical care, while those in poverty face significant barriers to managing the disease. The intersection of poverty and HIV often results in higher transmission rates, as limited access to education and healthcare prevents individuals from taking preventive measures. Additionally, gender dynamics influence HIV transmission, with women in certain societies having less autonomy over their reproductive health, increasing their vulnerability to infection.

◆ *Gender Dynamics*

Government policies and community initiatives play a significant role in shaping public responses to HIV. Some societies have successfully reduced stigma and increased awareness through education and advocacy campaigns, promoting early testing and treatment. Efforts to integrate HIV-positive individuals into the workforce and social institutions help combat discrimination and ensure they lead fulfilling lives despite their condition. Public health measures, such as accessible healthcare services and sexual education programmes, contribute to lowering infection rates and improving the quality of life for those affected.



◆ *Antiretroviral Therapy*

From a sociological perspective, experiencing AIDS in the social world cannot be separated from the stigma and discrimination it generates. Erving Goffman's (1963) classic work on stigma provides a foundational understanding of how individuals with HIV/AIDS are perceived as possessing a "spoiled identity" where the illness becomes a marker of social deviance rather than a medical condition. People living with AIDS are often viewed through moralistic and prejudicial lenses, especially in societies where the illness is linked to sexuality, drug use, or so-called "immoral behaviour." This social labelling, as explained by labelling theory, results in not only exclusion from community and family structures but also internalised shame, fear, and social withdrawal. Sociologists study how such stigma leads to structural barriers, including denial of employment, healthcare, and social services, reinforcing the marginalisation of already vulnerable populations. Thus, the lived experience of AIDS is not only about the physical progression of the disease but about navigating a deeply judgmental and unequal social world that shapes illness identities, healthcare access, and overall well-being.

### 3.2.1.2 Social Dimension of Pandemic Diseases

The social dimensions of pandemic diseases are:

#### 1. Social Disruption and Behaviour Adaptation

Social disruption refers to significant interruptions in the normal functioning of society, often caused by crises such as natural disasters, pandemics, wars, or economic collapses. These disruptions alter everyday routines, social norms, institutions, and relationships, leading to uncertainty and instability. For instance, during a flood, schools may shut down, people may lose homes, and access to basic services may be blocked causing both emotional and structural disarray. Behavioural adaptation is the process by which individuals and communities adjust their behaviours in response to such disruptions. These adaptations may be short-term (e.g., temporary migration or working remotely) or long-term (e.g., changes in hygiene practices, family roles, or community organisation).

For example, during the 2004 Indian Ocean tsunami, affected communities adapted by shifting from traditional housing to elevated or reinforced structures and adopting new disaster preparedness behaviours. During the COVID-19

◆ *Community organisation*

◆ *Interpersonal interactions*

pandemic, social disruption was widespread: schools, workplaces, and transport systems were closed; gatherings were restricted; and health systems were overwhelmed. In response, people adapted by wearing masks, using digital technologies for work and education, maintaining physical distancing, and redefining social rituals like funerals and weddings. These behavioural shifts reveal the resilience and adaptability of societies in times of crisis.

◆ *Pandemics disrupt*

Pandemics disrupt deeply ingrained social behaviours and force individuals and communities to change their behaviours to reduce disease transmission. Such changes involve interpersonal interactions, employment, education, and uses of public space, often creating fundamental alterations in how society functions and individuals behave. The immediate impact of any pandemic is the change it brings about in regular social practices. Greetings, such as handshaking, hugging, or gathering in large groups, gave way to online conferencing, bumping elbows, or limiting contact with others. During the recent COVID-19 pandemic, the need to maintain social distancing changed how milestone events were celebrated and losses mourned, including how people stayed in touch. Long-inhabited cultural norms of weddings, funerals, and other major life events shifted to online platforms.

◆ *Work from home*

This is reflected in the disruption pandemics have caused to the work and education sectors. The transition to work-from-home mode and online classes during COVID-19 presented the pace at which society can adapt to new realities. At the same time, though, such adaptation underlined various inequities, such as a digital divide where many citizens lack decent internet service or any complicated technology. The resultant disruptions highlighted the need for strong infrastructure to support these transitions equitably. Public spaces and consumer behaviours also undergo significant transformations. Markets, malls, and recreational areas often face closures or limited access, driving consumers to prioritise online shopping and delivery services.

◆ *Behavioural adaptation*

For example, during pandemics, the surge in e-commerce and telemedicine vividly illustrates how behaviour changes to meet basic needs safely. Simultaneously, other industries, such as those related to hospitality and travel, frequently incur catastrophic losses that take much longer to recover from. Social disruption broadly encompasses key elements of mental health and social isolation. A loss of face-to-face

interaction, in addition to feelings of fear and uncertainty, heightens levels of stress, anxiety, and depression. Prolonged disruption to routine and social connectivity raises the focus on including mental health support and interventions in pandemic responses. In the face of public health measures, behavioural adaptation varies across populations. While many would follow the guidelines on mask-wearing and vaccinations, others would resist because of some cultural beliefs or misinformation – or even distrust of authority. Public health campaigns and open, transparent communication are highly effective in building trust and convincing collective action, ensuring successful behaviour adaptation.

◆ *Relative Dynamics*

## 2. Community Solidarity and Fragmentation

Pandemics tend to bring out the best and the worst in human societies, from astonishing moments of community solidarity to episodes of social fragmentation. The balance of these relative dynamics depends on resource availability, public health measures in place, and cultural values. Pandemics often bring extraordinary acts of community, mutualism, and helping out one's neighbours – older ones, low-income families, and the sickly isolated. During the COVID-19 pandemic, many grassroots initiatives were organised, and mutual aid networks were established to bring food, medical supplies, and emotional support to those in need. Communities came together, beginning to unanimously honour health workers – a shared sense of purpose and gratitude.

◆ *Marginalised populations*

## 3. Impact on Social Inequalities

Pandemics deeply amplify old social inequalities, showing the vulnerabilities and gaps in essential resources and services, including healthcare, education, and economic opportunities. The marginalised populations usually bear a disproportionate burden, indicating systemic disparities that persist across societies. Some of the evident inequalities that arise with pandemics relate to access to healthcare. The rich have better access to quality healthcare, private hospitals, and all forms of treatment one may need. On the other hand, low-income or rural populations may lack essential services. For example, testing, vaccination, and access to critical care in underprivileged groups proved particularly challenging during the COVID-19 pandemic and underlined disparities in healthcare infrastructure between urban and rural areas or between high-income and low-income countries.

◆ *Economic vulnerabilities*

Other significant dimensions of social inequality in pandemics are economic vulnerabilities. Poor workers, especially in the informal sectors, are highly vulnerable because of a lack of employment security, health insurance, or savings. The lockdown policies and economic slowdown have hurt them disproportionately, pushing many into poverty. Those who belong to stable and remote-friendly professions suffer little disruption; it points to a sharp divide in economic resilience. Pandemics also exacerbate inequities in education, with the shift to online learning due to school closures favouring those with access to technology and reliable internet connections. Poor students from low-income families often cannot afford such facilities and thus forfeit their chances of learning. Indeed, studies conducted throughout the course of the COVID-19 pandemic showed significant setbacks among children in marginalised communities and exacerbated existing disparities in education.

◆ *Social Distancing*

Another important dimension of inequality is related to living conditions and vulnerability to disease. Poorer areas of residence are associated with high population densities due to crowded housing, unsanitary conditions, and inadequate clean water supplies that make it easier for contagious diseases to spread. People under such conditions are hardly able to keep up with guidelines for social distancing and hygiene during pandemics, which raises their risks of infection. On an international scale, pandemics paint a picture of inequalities in resource distributions. Richer countries always snag the vaccines, treatments, and protective apparatus earlier and more significantly than poorer countries, which struggle to meet minimum requirements. This has been well elaborated by the unequal distribution of COVID-19 vaccinations, where vaccination rollouts have been delayed in most developing nations. Besides, pandemics are accentuating gender inequalities. Women, in general, act as the first point of contact for their families or as health workers—a common occupation for them. Similarly, women in informal employment and caring sectors face job losses and income loss due to the pandemic. At the same time, the incidence of domestic violence escalates during lockdowns, further compounding risks to women's safety and well-being.

#### **4. Mental Health and Well-being**

Pandemics create conditions that are adversarial to the mental health and well-being of individuals and communities. Such outbreaks have psychological effects

◆ *Emotional Distress*

based on uncertainty, isolation, fear of illness, and disruption to livelihood; these often culminate in widespread emotional distress. Uncertainty and unpredictability are a feature of pandemics, and hence populations show an increase in the levels of anxiety and stress. People fear having the disease, their loved ones' health, and economic instability. During the COVID-19 pandemic, for example, anxiety disorders were reported mainly due to continued uncertainty over the path of the virus and its effects on society.

◆ *Social Control*

Social isolation and quarantine, though necessary for the control of the spread of disease, bring significant mental health consequences. Long-term isolation engenders loneliness, depression, and feelings of helplessness. Studies conducted during the COVID-19 pandemic demonstrated a significant rise in depressive symptoms in people who were confined to their homes, especially among those living alone or with limited support. Economic instability, loss of jobs, and financial uncertainty add to psychological distress. Chronic stress is commonplace in families struggling to meet their basic needs amidst a pandemic. It may have long-lasting mental health effects. Economic hardship bears disproportionately on the most vulnerable in society, with increased inequalities in mental health outcomes. Health workers and first responders are among the most vulnerable people in terms of mental health during pandemics. Long working hours, possible illness exposure, and carrying the weight of patients' suffering may develop into burnout and emotional exhaustion. Supportive networks and programmes for mental health, targeting these essential employees, will be imperative to mitigate these effects.

◆ *Changing Societies*

### 5. Cultural Shifts and Rituals

Regarding pandemics, cultural norms and rituals undergo a sea of change as societies continue to practice traditions, celebrate milestones, and mourn losses. Most of these changes are driven by public health measures limiting gatherings, such as social distancing; thus, long-held traditions must be adapted. Most religious and spiritual practices have been considerably changed by pandemic conditions, usually involving large groups. Churches, mosques, and temples could only allow a limited number of people inside the premises or hold online services. Virtual prayer meetings and live streaming of religious events became popular during COVID-19, thus continuing people's religious and spiritual observance while following safety protocols.

- ◆ *Using virtual platforms*

Major life events such as weddings, funerals, and naming ceremonies have drastically altered. Weddings were downscaled to smaller events or performed online. At the same time, funerals had their number of participants restricted, changing how a community expresses condolence and support for the bereaved. This has opened a debate on the actual meaning of these rituals and how well they can adapt to contemporary crises.

- ◆ *Providing accurate information*

## 6. Health Communication and Misinformation

Effective health communication is core to ensuring good public health by providing accurate information and enabling individuals to make informed decisions. However, misinformation often finds its way into everyday life and undermines these important efforts, posing considerable challenges to the intent of public health. Health communication involves strategies health organizations, governments, and the media use to educate or inform the public about health issues. This may include vaccination campaigns on hygiene and disease prevention. In a pandemic such as COVID-19, there is a great need for timely and proper communication concerning mask use, hand washing, and social distancing in containing the virus. It can be communicated through social networks, television, or community networks.

- ◆ *Lack of communication*

Social media and other virtual means of communication have posed serious barriers to health communication through the spread of misinformation. False claims about treatment, safety, and severity can result in confusion among the public, mistrust, and refusal to follow medical recommendations. In the case of the COVID-19 pandemic, for example, conspiracy theories related to ingredients in vaccines and their aftermath have contributed considerably to the problem of vaccine hesitancy within communities. Consequences associated with misinformation vary widely. Among these are the postponement of disease diagnosis, reduction in vaccination rates, and non-compliance with protective precautions that might prolong the disease process.

While NFHS-5 was conducted before and during the COVID-19 pandemic, it provides baseline health indicators that contextualise the pandemic's health impact. For example, pre-existing hypertension, diabetes, and obesity, especially in urban and ageing populations, made many more vulnerable to COVID-19 complications.

According to the NSSO Time Use Survey (2019) and the Periodic Labour Force Survey (PLFS 2020):

- ◆ Over 40 million informal workers lost employment during the initial lockdowns.
- ◆ Women's work hours declined, with an increase in unpaid domestic labour, indicating a gendered impact of the pandemic.
- ◆ Access to healthcare declined, particularly for non-COVID conditions, impacting continuity of care for chronic diseases.

## Summarised Overview

Acute and chronic lifestyle diseases, such as diabetes, hypertension, cardiovascular diseases, and obesity, are socially and behaviourally influenced. Urbanisation, a sedentary lifestyle, poor dietary habits, and stress are all major contributors to the rising incidence of these diseases. Socioeconomic disparities also contribute significantly; low-income groups always have poor access to good nutrition, health care, and a chance for physical activity. In addition, some of these lifestyle diseases, like obesity, will bear stigma that would affect the mental health and social well-being of individuals. Creating awareness and prevention and providing equal access to health care and wellness programmes must be approached with a multi-dimensional response. Amongst the most remarkable social dimensions, public health problems faced today include HIV/AIDS. This will often bring about social isolation, hence affecting the mental health and quality of life of the individual living with HIV. Socioeconomic factors, such as poverty and lack of education, increase the spread of the disease since it is hard for people to afford preventive measures and treatment. This significantly affects women and the most marginalised communities due to social inequities. Any intervention to address HIV/AIDS must emphasise awareness, destigmatisation, and accessible antiretroviral therapy in a framework of promoting social inclusion and support systems for affected individuals.

## Self-Assessment Questions

1. Explain HIV?
2. How many types of HIV?
3. How do sudden societal changes or disturbances affect its stability and functioning?
4. How does the sense of unity and mutual support among members of a community manifest and contribute to its well-being?
5. How do societal disparities influence access to resources and opportunities?
6. How can spreading health-related information and misinformation affect public understanding and decision-making?

## Assignments

1. Critically examine the consequences of social system breakdowns on communities.
2. Analyse how community unity and division among its members shape societal dynamics.
3. Explain the role of cultural practices and traditions adapted or evolved during global health crises like pandemics.

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## Suggested Reading

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4. Mathur, S. (2022). *Social pandemic: A terminally ill modern society*. Sage Publications.

### Space for Learner Engagement for Objective Questions

Learners are encouraged to develop objective questions based on the content in the paragraph as a sign of their comprehension of the content. The Learners may reflect on the recap bullets and relate their understanding with the narrative in order to frame objective questions from the given text. The University expects that 1 - 2 questions are developed for each paragraph. The space given below can be used for listing the questions.

SGOU



## Health and Social System

### Learning Outcomes

On completion of the unit, the learner will be able to:

- ◆ assess the interconnection between health and social systems
- ◆ explore occupational health and ageing
- ◆ analyse the social causes of sickness through attitudes, beliefs, values, and superstitions.

### Background

In this unit, the social causes of values and superstitions are based on the background that culture and society play a fundamental role in forming the beliefs and behaviours of the individual. Values and superstitions are not personal but strongly depend on broader social systems. From early childhood onward, individuals learn social norms and traditions that shape their worldview. Values are instilled through family, education, and religious teaching; such values often guide moral decisions and maintain social order. Similarly, superstitions arise from cultural practices and historical contexts as people try to explain uncertainties or misfortunes. Such beliefs are passed down through generations and are sustained mainly by community practice and peer influence. Such social causes reveal how socialisation processes perpetuate specific behaviours and belief systems. Thus, it offers a lens through which the complex interrelation between culture, society, and individual action can be viewed.

### Keywords

Social causes, Values, Superstitions, Socialisation, Cultural norms, Family influence



## Discussion

### ◆ *Health outcomes*

Health and social systems are intertwined structures that safeguard citizens' physical, mental, and social well-being. These include the structure for healthcare delivery, infrastructure related to public health, and mechanisms to address social determinants of health. Such initiatives together go a long way in offering equal access to health and enhancing resilience within the community. The health system includes all organisations, institutions, and resources committed to improving health. It involves preventive, curative, and rehabilitative services in hospitals, clinics, and through community health programmes. Effective health systems rely on competent health professionals, well-developed infrastructure, and equitable financing to ensure services reach society's most deprived sections. The social system: education, housing, employment, and social services have a crucial impact on health outcomes. Income inequality, nutritious food, and quality education all relate to the opportunity for maintaining health. For example, strong social support systems often translate into better health outcomes because individuals are more likely to receive timely care and adhere to health-promoting behaviours.

### **3.3.1 Health and Social System**

### ◆ *Frame of Social Structure*

The health and social system refers to the web-like framework of social structures, institutions, and relationships that shape health outcomes and the well-being of individuals and communities. It emphasizes that health is not just a matter of biology or an individual's concern but is also determined by social, economic, cultural, and environmental factors. This system can be understood only by looking at the roles played by different societal elements, such as family, religion, economy, and state, and broader influences like occupational health, environmental conditions, and societal attitudes.



Figure 3.3.1 health and social system

## 1. Family

◆ *Basic social Unit*

The family is one of the basic social units, leading to the development of individual health and well-being. As the primary source of emotional, social, and economic support, families influence health behaviours, access to care, and illness management. A supportive family environment fosters good health behaviours, a sound mind, and resilience to protect against physical and psychological diseases. Conversely, family dynamics such as conflict, neglect, or lack of support may lead to stress and poor health outcomes. The role of the family becomes even more crucial in the case of a chronic illness, as care, adherence to treatment, and emotional support become indispensable for recovery and quality of life.

The health of a family is interdependent, where the well-being of each member affects and is affected by the group as a whole. These are determined by socio-economic factors, cultural beliefs, and lifestyle choices within a family that generally shape health outcomes. For example, greater health literacy, like access to means, enables families to prevent and control illnesses. When major health crises occur, such as pandemics, family support becomes fundamental in maintaining emotional stability, observing precautions, and obtaining health care efficiently. Strengthening family bonds and empowering them with knowledge and resources is important in promoting holistic health and societal resilience.

## 2. Religion

### ◆ *Spiritual guidance*

Religion is among the most potent factors in health behaviours, perceptions, and outcomes since it imbues life with spiritual guidance, moral frameworks, and community support. Most religious traditions emphasise practices that promote health: dietary regulations, abstention from destructive substances, and rituals that foster mental and emotional well-being. Faith often brings solace to the individual during illness, hope, reduction of stress, and resilience. Religious communities can act as support networks by providing care, companionship, and resources for the ill.

## 3. Economy

### ◆ *Complex relationship*

The economy and health are interlinked in a complex relationship, influencing each other profoundly. A strong economy is the foundation of adequate healthcare systems since it assures sufficient infrastructure funding, medical research, and delivery of services. Economic growth improves living standards, nutrition, and access to education, crucial health determinants. This forms a vicious cycle because poor economic conditions often lead to inadequate health care, insufficient nutrition, and exposure to hazardous living and working conditions, all of which cause increased disease burden.

### ◆ *Universal health coverage*

At an individual level, health outcomes are greatly influenced by income and employment status. Higher incomes may afford better health care, healthier diets, and safer living environments. Usually, employment guarantees access to health benefits sponsored by employers, reducing out-of-pocket medical expenses. On the other hand, economic disparities lead to health inequities; under these disparities, the subordinate groups of society face barriers to access to quality care and, therefore, bear a higher rate of illness and premature death. Health, in turn, affects the economy's influence on productivity and workforce participation. Healthy populations are more productive and apt to contribute to economic growth, whereas widespread illness could strain public resources and reduce economic output. For example, pandemics or diseases that have become common could disrupt industries and increase expenditures on healthcare, thus jeopardising economic stability. Investments in health are investments in economic prosperity. Universal health coverage and policies that target preventive measures

contribute to health requirements or social determinants to break the poverty-disease-poverty cycle, bringing about sustainable, well-aligned systems that promote economic progress and societal well-being through health.

#### 4. State

##### ◆ *Equal access*

The state is central in safeguarding public health and ensuring that everybody has equal access to health care. Through policy formulation, resource provision, and the creation of healthcare infrastructure, governments set the context in which individuals and communities achieve optimal health outcomes. This includes the state's duties in regulating healthcare systems, funding public health programmes, and addressing the social determinants of health such as housing, education, and employment. All such efforts aim to reduce health disparities and increase overall societal well-being.

##### ◆ *Health Education*

A proactive state focuses on preventive healthcare by implementing vaccination programmes, health education, and legislation to reduce deleterious behaviours such as smoking or unsafe driving. Public health crises, such as pandemics or environmental disasters, underscore the need for a well-prepared state to marshal resources, spread accurate information, and provide timely medical interventions. Effective governance saves lives and strengthens public trust in health systems.

##### ◆ *Human Development*

Michel Foucault's concept of biopower elucidates how the state exercises control over populations by regulating bodies and health through policies, surveillance, and institutional practices. Rather than merely providing healthcare, the state shapes norms around health, defining what constitutes "normal" and "deviant" bodies. This anatomopolitics—the disciplining of individual bodies—and biopolitics—the regulation of populations—allow the state to govern through health interventions and social control mechanisms. Veena Das's ethnographic work highlights how the state extends its power by institutionalising health practices, often expanding its authority over marginalised communities by defining who is healthy or ill and managing access to care. Sharma and Gupta's *Anthropology of the State* further emphasise how health governance is a site where state power is negotiated, contested, and reproduced, showing that health is deeply embedded in the politics of power, identity, and citizenship. Thus, state regulation of health is not only about welfare but

also about controlling bodies and populations in line with broader social and political agendas.

### 3.3.1.2 Health and Ageing in Social System

Ageing is a biological process that significantly affects health and introduces challenges and opportunities into the social system. Along with ageing comes increased susceptibility to chronic diseases, decreased physical potential, and fragility of the mind through diseases like depression and dementia. This creates a demand for highly specialised health services that need long-term care. The social system plays an important role in assuring the satisfaction of these needs through resources, policies, and support networks geared toward an ageing population. Most societies undergo social changes with ageing, such as retirement, loss of social roles, and reduced income, which impact physical or psychological health. Supportive social systems, including family networks, community groups, and governmental programmes, buffer these effects. For instance, accessible health care, social security schemes, and age-friendly environments empower older persons to continue living independently and to enjoy a good quality of life. Programs that promote active ageing, such as lifelong learning and community engagement, are important for well-being and reduce the risk of social isolation.

◆ *Biological Process*

Ageing also brings cultural and intergenerational dynamics into focus. Older people often play important roles as caregivers, mentors, and custodians of cultural knowledge, contributing to the social fabric. In many societies, however, the breakdown in traditional family structures and poorly designed policies for elder care leave many older adults vulnerable. Only in an age-inclusive social system providing intergenerational interaction and contributions from older adults can dignity and health be genuinely realised. As populations worldwide are ageing, the dynamic interplay between health and ageing underlines the need for integrated approaches that harmonise healthcare, social services, and initiatives in the community. Allowing enabling environments and policies to be created, societies can embrace ageing as a period of continued growth and contribution to the well-being of individuals and the community.

◆ *Traditional Knowledge*

Everyone is unique with their own specific genetic, psychological, and social characteristics. The social class they belong to influences how an individual ages (referring to their experience). How a society handles its senior members

◆ *Elderly care*

is also a very important factor. Inadequate pensions, poor and unhygienic living conditions, occupational insecurity, and shortages of psychiatric and psychological services are some of the shortcomings in the care of the old. Societies differ regarding the care and handling of the elderly. While in developed countries the government takes the initiative to provide security to the aged, the problem still has not attracted the required attention in developing countries. However, some common elements in affluent and developing countries regarding dealing with the aged exist. In almost all societies:

- ◆ Despite hardships, most people try to survive as long as possible.
- ◆ Older people tend to disengage themselves from important social activities.
- ◆ The elderly who had played an active role in community affairs when they were young tend to withdraw from mainstream social interactions as physical and mental degeneration increases.
- ◆ Though numerically large, the aged are too heterogeneous to form an effective social pressure group.
- ◆ Though most senior members contribute to the family in terms of their services, such as looking after the young ones, managing the domestic front, and so on, they are still considered by some younger individuals as unproductive members. This perception may stem from economic dependency or more complex emotional and social security needs that the elderly often express but are frequently denied by younger generations.

### **3.3.1.3 Ageing and Morbidity in Kerala**

Kerala presents a unique case in India due to its advanced demographic transition characterised by low fertility and increasing life expectancy, resulting in a rapidly growing elderly population. While Kerala enjoys relatively better health indicators and social development compared to other states, the demographic shift has led to an increased prevalence of chronic morbidities and age-related illnesses such as hypertension, diabetes, cardiovascular diseases, and arthritis among the elderly. This growing burden of chronic conditions poses challenges to the healthcare system and social support structures. Additionally, the traditional family

◆ *Economic Security*



support system is weakening due to urbanisation, migration, and changes in family dynamics, leaving many elderly persons vulnerable to social isolation and inadequate care. These issues highlight the need for comprehensive policies and community-based interventions that address not only the physical health but also the social and psychological well-being of Kerala's ageing population.

### 3.3.1.4 Health and Environment

Environmental degradation, resulting from factors such as pollution, deforestation, industrialisation, and unsustainable agricultural practices, has a direct and profound impact on public health. Environmental sociology helps us understand the intricate relationship between human activities, ecological changes, and health outcomes, emphasising how social structures and inequalities influence exposure and vulnerability to environmental hazards.

◆ *Environmental hazards*

#### 1. Air Pollution and Respiratory Diseases

One of the most significant health consequences of environmental degradation is the rise in respiratory illnesses due to air pollution. Industrial emissions, vehicular exhaust, burning of fossil fuels, and open burning of waste release harmful particulate matter (PM2.5 and PM10), nitrogen oxides, sulphur dioxide, and other toxins into the atmosphere. Prolonged exposure to polluted air can lead to chronic conditions such as asthma, bronchitis, Chronic Obstructive Pulmonary Disease (COPD), and even lung cancer. Urban populations, especially in industrialised and rapidly urbanising areas, bear the brunt of these ailments.

◆ *Industrial emission*

#### 2. Water Pollution and Waterborne Diseases

Contamination of water bodies through chemical runoff, untreated sewage, and industrial waste leads to the spread of waterborne diseases such as cholera, dysentery, typhoid, and hepatitis. A poor sanitation and unsafe drinking water continue to be critical health challenges in many developing regions. Moreover, heavy metals like arsenic and lead present in polluted water sources can cause long-term health problems, including neurological disorders and cancers.

◆ *Contamination of water*

#### 3. Soil Degradation and Food Safety

Soil contamination through pesticides, herbicides, and

◆ *Deforestation*

heavy metals affects food quality and safety. Consumption of crops grown in polluted soils can lead to bioaccumulation of toxins in the human body, resulting in diseases such as cancer, neurological disorders, and reproductive health issues. Additionally, soil erosion and loss of fertile land due to deforestation and unsustainable farming reduce food security, indirectly affecting nutritional health.

◆ *Environmental disaster*

Environmental degradation also exacerbates climate change, which in turn influences the spread of vector-borne diseases such as malaria, dengue, and Zika virus. Rising temperatures and altered rainfall patterns create favourable conditions for vectors like mosquitoes to thrive in new geographical areas, increasing disease incidence. Climate change also contributes to heat-related illnesses, malnutrition due to crop failures, and mental health stress from environmental disasters.

◆ *Industrial Hazards*

#### 5. Social Inequality and Vulnerability

Environmental sociology stresses that the health impacts of environmental degradation are not evenly distributed. Marginalised communities, including low-income groups, indigenous populations, and those living in environmentally hazardous zones, often face disproportionate exposure to pollutants and lack access to adequate healthcare. This structural inequality leads to greater disease burdens among the socially disadvantaged, highlighting the need for environmental justice and equitable health policies.

◆ *Poor Living Conditions*

Environmental degradation disproportionately affects vulnerable groups, such as low-income communities, children, and the elderly, exacerbating existing health inequalities. Sociologists analyse how urbanisation and industrialisation increase exposure to pollutants, hazardous chemicals, and poor living conditions. For example, air pollution, a leading cause of respiratory and cardiovascular diseases, is most severe in overcrowded urban areas, where lower-income populations live near industrial zones and congested traffic networks. Similarly, water contamination and inadequate sanitation disproportionately impact rural communities, where access to healthcare is already limited, reinforcing cycles of poverty and disease.

Climate change further intensifies these disparities by altering disease patterns, increasing extreme weather events, and reducing food security. Rising temperatures and erratic rainfall contribute to the spread of vector-borne diseases like malaria and dengue, disproportionately affecting populations with limited healthcare access. Sociologists view climate change as an environmental issue and a social justice crisis, where the wealthy contribute significantly to carbon emissions while vulnerable populations suffer the consequences.

◆ *Food Security*

Environmental protection is a public health necessity and a socio-political issue requiring systemic change. Policies aimed at sustainability, clean energy, and waste management directly shape community health, particularly in developing nations like India. Urban planning decisions such as allocating green spaces, access to safe water, and pollution control measures are tied to government priorities and economic interests. The push for environmental justice involves activism, legal advocacy, and international cooperation, ensuring that health equity is prioritised alongside economic growth.

◆ *Legal Advocacy*

Integrating public health strategies with environmental sustainability is essential for creating liveable communities. Sociologists emphasise the need for multi-sectoral collaboration to address environmental health disparities, advocating for policies that protect vulnerable populations while promoting sustainable development. As climate challenges escalate, social movements pushing for environmental justice and equitable health access become increasingly critical in shaping a sustainable and healthier future.

◆ *Sustainable development*

### **3.3.1.5 Social Cause of Sickness**

Sickness is not merely a biological phenomenon; social forces strongly drive health outcomes and healthcare access. Dominant players in social determinants predisposing to illness are the causes of ill health: poverty, education, housing, and employment. For example, societies with low-income conditions have insufficient access to wholesome food, water, and health services, which predispose communities to communicable and non-communicable diseases. Poor living conditions, such as crowded housing or exposure to environmental hazards, only increase health risks and compound a cycle of illness and disadvantage.

◆ *Healthcare access*

◆ *Social norms*

Cultural and social norms also play a part in illness through the creation of influences on health behaviours and attitudes. In many societies, traditional beliefs or stigma discourage people from seeking early care for diseases such as HIV/AIDS and those relating to mental health. Further, gender roles and inequalities impact health, as women and marginalised groups have limited access to resources and a voice in decision-making regarding their health.

◆ *Mental health problems*

The social structures, such as policies and economic systems, may also perpetuate health disparities. For example, the unavailability of affordable healthcare or social safety nets leaves people experiencing poverty without the wherewithal to handle chronic illnesses or recover from acute conditions. Added to this are social stressors like unemployment, discrimination, and isolation, which are linked with higher rates of mental health problems and diseases related to stress.

◆ *Health equity*

The social causes of sickness demand an approach to confront inequity and advance health equity. Education, employment, housing, and healthcare access policies can significantly reduce disease burden. Also, community-based interventions must be cited with respect for cultural contexts and involve populations locally in decision-making. Thus, societies will be able to build healthier and more resilient communities and realise that health is a right, not a privilege.

**a. Attitude**

◆ *Cultural norms*

The development of attitudes, the readiness of people to think, feel, or act in specific ways, is largely socially determined. These include cultural norms, family influences, peer interactions, education, and media exposure. From an early age, individuals begin to adopt beliefs and values from their family and community that form a foundation for their attitudes toward different aspects of life, such as health, work, relationships, or societal problems. For instance, a child raised in a society that values education is likelier to develop a positive attitude toward learning.

◆ *Gender role*

Cultural and social norms also contribute to forming attitudes about acceptable or desirable behaviour within a group. Social norms affect attitudes toward gender roles, religious practices, and health behaviours. For example, in some cultures, the stigma associated with mental illness may create negative attitudes toward seeking psychological help. Similarly, stereotypes portrayed in the media and education perpetuate prejudices and form people's attitudes toward other social groups.

◆ *Impact attitudes*

Peer and group influences also strongly impact attitudes, especially during adolescence and early adulthood. The need for social acceptance often makes people adopt attitudes and behaviours that align with those of their peers. Examples can be seen in the use of substances, choice of career, and political views. Also, education and access to information change attitudes by broadening people's horizons and challenging their perceptions. Media plays a double role in attitude formation in every traditional and digital form: it reflects and shapes social attitudes. Positive representations in the media would encourage inclusiveness and progressive thinking, whereas sensationalism or biased reporting might encourage falsehoods and divisiveness.

◆ *Critical thinking*

Nurturing environments that allow critical thinking, inclusiveness, and open dialogue address the social causes of attitudes. More attention should be given to the challenge of negative stereotypes through the education systems, media platforms, and community programmes. Such social influences can only be fostered in the way that societies will nurture attitudes to promote empathy, collaboration, and progress.

**b. Beliefs**

◆ *Reinforcing beliefs*

Social factors deeply influence beliefs, as individuals' perceptions of the world are shaped by the societies and cultures they belong to. From early childhood, family, education, community, and the broader cultural environment play a crucial role in forming and reinforcing beliefs. As the primary social unit, the family often instils foundational beliefs about religion, morality, gender roles, and social behaviour. These early lessons create a framework individuals carry throughout their lives, influencing their interactions and decisions.

◆ *Shared responsibilities*

Cultural norms and traditions also significantly impact beliefs, as they dictate what is considered acceptable or taboo within a particular society. These social standards define how individuals view themselves, others, and the world around them. For instance, cultural beliefs surrounding marriage, family, and social hierarchies shape individuals' expectations and behaviours within these contexts. In some societies, collectivist beliefs promote the importance of community and shared responsibilities, while in individualistic societies, personal autonomy and achievement are more highly valued.

◆ *Educational system*

The education system plays a vital role in shaping beliefs by exposing individuals to new ideas, diverse perspectives, and critical thinking. Educational institutions provide the tools for questioning inherited beliefs, challenging existing norms, and embracing new worldviews. However, the content and biases within educational systems can also reinforce prevailing social ideologies, perpetuating specific beliefs related to race, class, or gender.

◆ *Media representation*

Traditional and digital media further amplify social beliefs by disseminating cultural narratives, reinforcing stereotypes, and shaping public opinion. Media representations of political, social, and economic issues often mould collective beliefs by framing them in specific ways. The portrayal of race, gender, and identity in media can either challenge or reinforce stereotypes and social expectations. Group dynamics and socialisation within peer groups or social circles also heavily influence beliefs. People often adopt beliefs that align with their social groups to maintain belonging or acceptance. This is evident in political ideologies, religious practices, and consumer behaviours, where individuals may align their beliefs with the values of their social networks.

**c. Values and Superstitions**

◆ *Cultural practices*

Values are principles and standards of behaviour and actions that people prefer to have; therefore, they have a very tight relationship with structures and cultural practices in society. Since individuals form, maintain, and develop their opinions and behaviours significantly through family members and others with whom they socialise, in addition to community, education, religion, and societal norms, they obtain values from those sources from early childhood. For example, a culture that strongly emphasises the well-being of all its members and cooperation may instil in its members values that are oriented toward the community. On the other hand, more individualistic societies encourage values with a greater degree of personal success and self-sufficiency.

◆ *Religious traditions*

Cultural and religious traditions have the potential to powerfully shape values by giving directives on what is right or wrong and providing guidelines concerning social behaviour. These values guide everything from attitudes toward work and family to perceptions of social justice and morality. Many cultures, for instance, consider respect for the elderly, hard work, and loyalty to the family as values from which individual behaviours and expectations are formed.

Other socialisation processes, such as those that come about through exposure to media, education, and peer influence, reinforce these values, helping people adjust to social norms.

◆ *Social constructs*

On the other hand, superstitions are beliefs that originate from an attempt to make sense of uncertain things or control things that are not under one's control. Most superstitions are passed down through generations and are deeply ingrained in cultural, historical, and social contexts. They can develop to explain diseases, death, or bad luck when scientific understanding is inadequate, and they often continue by tradition. For instance, beliefs in omens, such as black cats crossing one's path or believing in lucky or unlucky numbers, can be shared in certain cultures or regions. Superstitions are generally social constructs, reinforcing collective behaviours and attitudes, though they may lack empirical evidence or a scientific basis.

◆ *Avoid stigma*

The force of social influence often explains that if an individual belongs to a community where certain superstitions or practices prevail, he or she will easily follow them to be accepted and avoid stigma. Therefore, peer pressure, family tradition, and religious practices nurture superstition, even with the increased spread of scientific knowledge in contemporary society.

◆ *Social influence*

While values are often responsible for promoting social cohesion and ethical behaviour, superstitions provide a sense of comfort and control over an otherwise unpredictable world. Both values and superstitions restrain individual behaviour, affect decision-making, and perpetuate social inequalities. Education and critical thinking will challenge old superstitions and promote more rational, evidence-based values in such cases. Moreover, the balance between preserving valuable traditions and the need for progress and enlightenment can be met by encouraging open dialogue and respecting diverse cultural perspectives.

## Summarised Overview

The health and social system brings in the interplay among the structures, institutions, and societal outcomes in health, emphasising that biological factors determine health and include social, economic, cultural, and environmental influences. This system contributes to understanding the role of different social components in promoting or hindering health and well-being. The family is the basic unit of health where support is found, care is provided, and health behaviours may be modelled through shared values and practices. Religion significantly shapes attitudes toward health and illness and guides dietary habits, hygiene, and healing practices. The economy controls access to all resources, including health care services, nutritious food, and safe living conditions; socioeconomic disparities have substantial health effects. The state is a central actor in the assurance of equitable health care through its policies, the development of infrastructures, and public health programmes; governance thus becomes one of the main determinants of population health.

## Self-Assessment Questions

1. Define ageing.
2. How can certain traditional beliefs and practices be understood as forms of superstition?
3. What societal factors contribute to the development and persistence of beliefs in a community?
4. How does the study of ageing from a sociological perspective shed light on the experiences of older adults in society?
5. Discuss social factors that shape the values and superstitions prevalent in society today.

## Assignments

1. Examine how spiritual beliefs and rituals influence individuals' approaches to health and healthcare practices.
2. Analyse the role of government involvement in shaping the health and well-being of populations.
3. Discuss the societal conditions that contribute to the prevalence and spread of illness within communities.



4. Explain the social factors that shape individual perspectives and behaviours.
5. Evaluate how cultural traditions and collective experiences contribute to the formation of shared beliefs and practices, including superstitions

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## Rehabilitation

### Learning Outcomes

On completion of the unit, the learner will be able to:

- ◆ evaluate key rehabilitation principles
- ◆ analyse agencies of rehabilitation
- ◆ assess the problems of therapy and rehabilitation

### Background

Rehabilitation is that part of health care aimed at recovering an individual from physical, mental, or emotional disabilities arising from injury, illness, or disease. The background of rehabilitation lies in the fact that recovery is not just about medical treatment but also includes holistic approaches that address various dimensions of an individual's well-being. Historically, rehabilitation has developed from simple physical therapy practices to a broad multidisciplinary field, including physical, occupational, speech, and psychological therapies. It is based on the knowledge that, in most cases, effective recovery requires more than just the treatment of the condition. It involves the empowerment of individuals, the improvement of their quality of life, and the regaining of independence. With the rise in chronic conditions, disabilities, and ageing populations, rehabilitation has become part of every healthcare system in the world. Its development has been guided by the advances made in medical science, social models of care, and the rising appreciation for the social and emotional dimensions of recovery. With the development of rehabilitation, much emphasis has been placed on accessibility, specialised care, and continued support so that people with health challenges can lead healthier and more enriching lives despite their health.

### Keywords

Rehabilitation, Holistic care, Patient-centred care, Multidisciplinary approach, Physical therapy, Occupational therapy



## Discussion

- ◆ *Healthcare professionals*

The discussion around rehabilitation highlights its fundamental importance in restoring the well-being of individuals affected by illness, injury, or disability. Rehabilitation encompasses a broad spectrum of interventions to improve physical and mental health and enhance quality of life. Central to rehabilitation is recognising that recovery is not just about curing a condition but involves empowering individuals to regain independence, functionality, and self-worth. This process typically involves a multidisciplinary approach, with a team of healthcare professionals working together to address various aspects of an individual's health, including physical, psychological, and social well-being.

### 3.4.1 Rehabilitation

- ◆ *Independence for the client*

Rehabilitation means restoring or recovering the biological, psychological, and social functioning of an individual lost or impaired due to injury or disability. It is based on the belief that all individuals are worthy and have the right to be masters of their health care. The goal of rehabilitation is to regain maximal functioning and independence for the client. In the case of brain injury, not only are the functions of the areas of damage lost, but it also affects the region of the brain distal to the site of injury anatomically connected to the damaged area. This is called 'diaschisis'. The brain also can take on the role of its damaged part. This is termed as the principle of equipotentiality. One of the fundamental objectives of rehabilitation is to prevent complications in such cases. Thus, rehabilitation is a process of adaptation or recovery from disability or a functionally limiting condition, whether temporary or irreversible. This recovery or restoration of functions could be typical or near normal.



Figure 3.4.1 Rehabilitation

### 3.4.1.1 Types of Rehabilitation

Rehabilitation refers to a set of interventions designed to optimise functioning and reduce disability in individuals with health conditions in interaction with their environment. The main types of rehabilitation include:

1. **Physical Rehabilitation:** Focuses on restoring mobility, strength, and physical function, often after injuries, surgeries, or chronic conditions like stroke or arthritis. It involves physiotherapy, occupational therapy, and exercises.
2. **Psychosocial Rehabilitation:** Aims at improving social functioning, emotional well-being, and mental health, often for individuals with psychiatric disorders or substance abuse problems.
3. **Vocational Rehabilitation:** Helps individuals regain skills or acquire new ones to return to work or find employment after illness, injury, or disability.
4. **Cardiac Rehabilitation:** Specialized rehabilitation to improve heart health and physical fitness following cardiac events such as heart attacks or surgeries.
5. **Pulmonary Rehabilitation:** Helps people with chronic respiratory diseases like COPD to improve breathing and quality of life.
6. **Neurological Rehabilitation:** Targets recovery from nervous system disorders such as stroke, traumatic brain injury, spinal cord injury, and multiple sclerosis.
7. **Substance Abuse Rehabilitation:** Provides medical and psychological support to overcome addiction and regain normal functioning.

### 3.4.1.2 Medical Conditions Commonly Addressed through Rehabilitation

Rehabilitation evolved from focusing solely on disease treatment to considering the patient's environment, social context, and personal goals. It emphasises empowerment and reintegration into society.

Rehabilitation is applicable across a broad spectrum of health conditions, including but not limited to:

- ◆ **Chronic diseases:** such as diabetes, cardiovascular diseases, chronic respiratory diseases, and arthritis.
- ◆ **Neurological disorders:** including stroke, cerebral palsy, Parkinson's disease, multiple sclerosis, spinal cord injuries, and traumatic brain injury.
- ◆ **Musculoskeletal conditions:** fractures, amputations, burns, and injuries affecting mobility.
- ◆ **Mental health disorders:** depression, schizophrenia, bipolar disorder, and substance abuse.
- ◆ **Post-surgical recovery:** rehabilitation after surgeries like joint replacements, cardiac surgery, or cancer treatments.
- ◆ **Developmental disabilities:** autism, intellectual disabilities, and congenital disorders.
- ◆ **Sensory impairments:** hearing loss, visual impairments.

### 3.4.1.3 Principles of Rehabilitation

There are several rehabilitation principles; some are general principles that reflect the general approaches and specific ones that explain the underlying recovery mechanism. The present section will discuss the 'principles' in the former sense. Outlined are the following principles of rehabilitation

#### a. Promote Adaptation

Recovery of functions impaired by disability or injury can only be completed to the maximum extent by simultaneously creating an environment for adaptation. The prime aim of rehabilitation is to help the individual adapt to the day-to-day demands of life, which sometimes require a change in the client's lifestyle. Therefore, the rehabilitation professionals need to prepare the client for this change. People with developmental disabilities often would not be able to return to a normal level like that of their regular counterparts. The client and family members should accept this rather than fostering false hopes for normalcy. In the case of an acquired disability, though, the emphasis is more on adjustment to the life-changing event. Expressed emotions such as

- ◆ *Individual adaptation*

anxiety, depression, or anger of the family member due to the disability often complicate the process of rehabilitation. Hence, they must be trained to deal with them effectively.

### **b. Emphasising Ability**

This is one of the key principles of rehabilitation. Most people with disabilities, whether due to a traumatic incident or those acquired during childhood, might have disabilities in some regions of functioning, whereas other areas of functioning may remain intact. For instance, a person with a locomotor disability may have his speech and intellectual functions intact. Rehabilitation professionals should train these people to develop these functions to the fullest extent and use them to compensate for the functions affected by disease or disability. This may give the client a sense of accomplishment.

◆ *Childhood disability*

### **c. Treat the Client as a Whole Person**

In rehabilitation, we treat a person and not a 'disease'. The person with the disability should be treated as a holistic being. Denial and non-acceptance of limitations cause anger and depression in the client. Unconditional regard for the individual with a disability plays a vital role in enhancing the psychological well-being of such clients. Attempts should be made to enhance a sense of self-efficacy in people with disabilities. It restores confidence and determination in overcoming many physical and psychological obstacles.

◆ *Depression of the Client*

### **d. Disability Affects the Entire Family**

Disability in a member of any family affects the entire family, as all members of the family share the trauma, physical cost, and psychosocial burden. This is not only because of close interpersonal ties between the family members but also due to the demand for their involvement in the care of the person with a disability. Hence, in a way, treating a person with a disability is also like treating his family members as well. Hence, time should be spent primarily with family members, listening to them and advising them, helping them overcome their negative, overwhelming emotional feelings and empowering them to cope with such family stresses effectively.

◆ *Emotional Feeling*



### 3.4.1.4 Agencies of Rehabilitation

#### 1. State Agencies

##### ◆ *Social welfare*

State agencies are institutions or organisations headed by the government that offer systematic and accessible rehabilitation services to all members of the public. They are customarily financed through taxpayers and work within strict mandates on social welfare. Most of these agencies focus on broad areas such as health care, education, and social integration.

##### a. **Medical Rehabilitation**

##### ◆ *Specialised healthcare*

It is the specialised healthcare that would help patients regain physical, mental, and social functioning during the recovery period from illness, injury, or chronic conditions. Rehabilitation can comprise various services that enhance a person's quality of life and independence. These therapies are often targeted to meet specific needs, such as restoration of mobility after surgery, management of chronic pain, or mitigation of the effects of neurological conditions. Healthcare-based rehabilitation is delivered through various settings, including hospitals, outpatient clinics, and community care centres, and often by a multidisciplinary team of healthcare professionals.

##### ◆ *Occupational therapy*

Physical rehabilitation, mainly including physiotherapy and occupational therapy, enables patients to regain lost strength and mobility for functionality. Neurological rehabilitation includes patients after strokes, spinal cord injury, or neurodegenerative diseases, with particular emphasis on regaining motor functions and teaching adaptive strategies for daily functioning. Cardiac and pulmonary rehabilitation programmes address patients after heart attacks and chronic respiratory conditions, respectively, by combining physical exercises, nutritional advice, and lifestyle counselling. It can also provide mental health rehabilitation access to services related to counselling, therapy, and medical treatments that are associated with depression, anxiety, and post-traumatic stress disorder. Advancing technologies, including robotic-assisted therapies and telerehabilitation platforms, have made healthcare-based rehabilitation services more accessible, effective, and inclusive. These programmes address the dimensions of recovery – both physical and psychological – and are thus fundamental to enabling individuals to lead fulfilling lives while reducing the long-term burden on healthcare systems.

## b. Social Rehabilitation

### ◆ *Social inclusion*

Social rehabilitation treatment somehow provides a way for the person to reincorporate into society after any situation disrupts an individual's ability to function socially or economically. This social rehabilitation includes problems related to such specific conditions of marginality, dependants, abused victims, disabled people, ex-offenders, and displaced persons due to conflict or natural catastrophes. Therefore, social rehabilitation provides such individuals with the skills, aid, and other resources that would allow them to reclaim their former independence, self-respect, and roles of usefulness within society. While social rehabilitation would cover the centres for vocational training, counselling, education, and skill development necessary for the particular needs of the victims, people with an addiction and substance use disorder might be counselled with therapy and life skills training to reconstruct their lives.

### ◆ *Social rehabilitation*

Other victims, such as sex-offenders, might need programmes focused on job placement and social reintegration. Social rehabilitation requires multi-stakeholder collaborations by the government with NGOs and community groups to ensure a comprehensive participatory model. It is in this sense of social inclusion and equality that social rehabilitation becomes crucial. Addressing different kinds of barriers improves not only the individual lives of the members of vulnerable populations but also the cohesiveness and resilience of the community. Accordingly, in contemporary society, social rehabilitation is a fundamental means to promote human dignity, equity, and justice as an expression of collective responsibility to care for those in need.

## 2. Private Agencies

### ◆ *Medical rehabilitation*

Private agencies for rehabilitation complement the efforts of the state by providing more specialised and individualised care to persons recovering from physical, mental, or social setbacks. These are private hospitals, clinics, NGOs, and for-profit organisations offering a wide range of services, from medical rehabilitation to social reintegration programmes. Their focus often extends to niche areas, such as cutting-edge treatments for chronic illnesses, holistic mental health care, or targeted vocational training programmes for marginalised populations. Unlike state agencies, private entities often have the flexibility to innovate and adapt quickly to emerging rehabilitation needs.



◆ *Advanced therapies*

Medical rehabilitation is a vast area where private agencies excel. These include advanced therapies, such as robotic-assisted physical therapy, intensive care for neurological conditions, and specialised mental health interventions. Indeed, most private hospitals and clinics have specific rehabilitation programmes for various conditions, such as stroke recovery, chronic pain, or addiction, combining modern technology with evidence-based practices. Such facilities are beneficial in areas where the general healthcare system may be overburdened or under-resourced, ensuring timely and effective access to rehabilitation services.

◆ *Community-based organisations*

The role of private agencies in social rehabilitation is no less important. Some NGOs and community-based organisations are engaged among the marginalised groups, including victims of domestic abuse, trafficking, or substance abuse survivors, by providing shelter, counselling, skill development, and job placement services to rebuild lives. Similarly, corporate-funded initiatives, generally through CSR, support various rehabilitation works, from community health projects to disaster recovery programmes.

◆ *Social service*

While private agencies greatly help in expanding and maintaining quality rehabilitation services, they also create problems regarding affordability and access to their rehabilitation facilities by indigent people. Generally, however, the collaboration between the private and state agencies can increasingly address such issues as discussed in public-private partnerships to make these services both comprehensive and inclusive. Private agencies remain indispensable in raising rehabilitation standards and bridging healthcare and social services gaps globally.

◆ *Accessibility issues*

### **3.4.1.5 Problems of Therapy and Rehabilitation**

Therapy and rehabilitation have significant problems, from accessibility issues to the number of facilities and specialists available. Accessibility may be difficult due to a shortage in some rural or underprivileged areas. The costs related to sophisticated therapies or extended periods of rehabilitation may place therapy beyond the means of such individuals with inadequate insurance and disposable income. Other factors include long travel distances to centres and geographic constraints that worsen such problems, leaving many without the required care for complete recovery or reintegration into society.

◆ *Social Attitude*

Stigma and social attitudes remain some of the significant barriers, especially for rehabilitation associated with a mental health condition, substance abuse, or disabilities. In most cultures, therapy is viewed as a sign of one's failures or weaknesses; hence, it discourages people from seeking help. Such misconceptions ultimately result in isolation and delays in treatment, making the prognosis worse. Cultural norms coupled with a general lack of awareness of the benefits of rehabilitation add depth to these challenges. Outreach and education become critical in order to overcome these barriers.

◆ *Regulatory frameworks*

Quality and standardisation of services are another concern: rehabilitation facilities are often at uneven levels of care, with some lacking qualified professionals or necessary equipment. These standards are also quite inconsistent in the case of treatment protocols, and appropriate monitoring mechanisms are not in place. Poor standards translate into poor patient outcomes. Most regions lack robust regulatory frameworks to ensure the implementation of such standards, and deficiencies like these undermine the effectiveness and safety of rehabilitation programmes. Psychological resistance includes states of denial or frustration and the low motivation of patients themselves. Less-than-aware programmes of patients' emotional needs contribute to higher dropout rates.

◆ *Quality of Service*

Resources remain a constant thorn in rehabilitation, hindering the success of programmes in terms of a shortage of trained personnel, inadequate infrastructure, and a lack of specialised equipment. Public systems are overcrowded and thus experience delays before receiving care. On the other hand, post-therapy support is almost nil, resulting in recidivism or deterioration. Many rehabilitation programmes come to an abrupt end without follow-up mechanisms put in place to help them face life's challenges.

◆ *Health restoration after illness*

### **3.4.1.6 Health & Rehabilitation**

Health and rehabilitation go hand in hand, considering that rehabilitation gives the primary basis for health restoration after an illness, injury, or surgery. Health broadly encompasses physical, mental, and social well-being, and rehabilitation addresses these dimensions of health. Rehabilitation is the medical, therapeutic, and supportive process that enables patients to recover from impairments, minimise disability, and attain the highest possible functional independence. This is an essential process of return to health and optimum well-being, be it through physical therapy

after a stroke, psychological counselling following trauma, or recovery from substance abuse.

For physical health, rehabilitation is crucial in recovery following accidents, surgeries, or chronic conditions. For instance, physical rehabilitation helps patients regain strength, mobility, and functionality after fractures, joint replacements, or spinal cord injuries. By improving muscle strength, joint flexibility, and overall body coordination, rehabilitation allows individuals to regain their independence and carry out daily activities more efficiently. These rehabilitation programmes aim to manage symptoms and improve cardiovascular and long-term wellness through exercise, diet, and education on chronic diseases like heart disease or diabetes. The interrelationship between health and rehabilitation in these instances draws into focus the fact that rehabilitation is not only to cure but also to prevent further deterioration and to help individuals lead more fulfilling and independent lives.

◆ *Independent lives*

Apart from physical health, it also plays a significant role in mental and emotional health. Most people with severe bodily injuries or ailments go through emotional setbacks like depression, anxiety, and post-traumatic stress disorder. Mental health rehabilitation counters these issues by offering psychological support, counselling, and coping strategies that help people deal with the emotional impact brought about by their condition. Programs designed specifically for recovery in mental health, like therapy for depression or anxiety, will not only promote the enhancement of an individual's mental health but will also support a smooth, general recovery by reducing emotional barriers to physical healing. Rehabilitating an individual supports one's general health through emotional and psychological strengthening of individuals.

◆ *Individual support system*

Rehabilitation encourages social health as individuals can go out and interact with people within society and in social circles. It helps them deal with the hardships of returning to work, school, or family life after illness or injury. Rehabilitation improves social function by making it possible to resume family, workplace, and community roles by improving physical and mental health. The social aspect of rehabilitation is also critical in maintaining long-term health, providing a sense of purpose and meaning, belonging, and being cared for, all of which contribute to social connectedness. This is essentially well-being.

◆ *Encouraging social life*

### 3.4.1.7 Importance of Rehabilitation

- ◆ *Structured support*

It plays a critical role in restoring, developing, and maintaining the health of an individual who has previously faced inevitable physical, mental, and emotional adversities. The significant activity within rehabilitation is focused on a person regaining independence in activities of daily living; the quality of life has been improved, and deterioration delayed or prevented. Whether recovering from a physical injury, managing a chronic illness, or overcoming a mental health challenge, rehabilitation provides the structured support necessary for achieving and maintaining optimal health. The rehabilitation process addresses the immediate effects of illness or injury, helps prevent future complications, and improves long-term health outcomes.

- ◆ *Return to normal life*

Rehabilitation is essential for many reasons, as it allows the healing and return to normal activities and functions of persons with disabilities and injuries. Many cases of stroke and significant surgery experience a range of difficulties in locomotion, talking, or carrying out activities of daily living. Rehabilitation programmes include physical, occupational, and speech therapy aimed at helping patients regain lost capabilities and learn new ways of performing tasks. Focusing on structured support is essential to improving a patient's general health, enabling them to restore autonomy and be less dependent on others. Without rehabilitation, many people are likely to be forced into lifelong disability, thereby reducing the quality of life and increasing healthcare costs.

- ◆ *Therapy and counselling*

Besides physical recovery, rehabilitation plays a significant role in mental health, emotional well-being, and social reintegration. Among people recovering from serious illness or injury, many have emotional challenges such as anxiety, depression, or post-traumatic stress. Psychological support, counselling, and behavioural therapy are commonly included in rehabilitation programmes to help cope with and process feelings, thus building resilience. This holistic approach to rehabilitation ensures that people recover physically, emotionally, and mentally, fostering a sense of well-being and mental strength, which is crucial for successful long-term recovery. Rehabilitation programmes use therapy and counselling in cases of addiction to handle the mental health of a person to avoid relapsing.

The social nature of rehabilitation is also very significant. Rehabilitation programmes are aimed at helping individuals

◆ *Social interactions*

regain their previous social and professional lives, enabling them to return to their social roles. This may be returning to work, associating with family, or participating in community activities. Rehabilitation aids a person's social interaction and the re-establishment of their routine, thereby increasing their sense of purpose and keeping them connected to others, which is an essential ingredient in the overall well-being of the individual. It helps one get back into everyday life and makes them less isolated and more connected, which is necessary for mental health and resilience.

◆ *Prevention*

Besides, rehabilitation is not only recovery but also prevention. This is because rehabilitation can impede further health complications by treating the root causes of the illness or injury. Examples include rehabilitation programmes for chronic diseases: patients with heart disease or diabetes start exercising, improve their nutrition, and practise stress management to prevent their condition's worsening and overall health. Equally important, mental health rehabilitation arms the person with a variety of strategies and tools that help to handle stress, regulate emotions, and even avoid the relapse or recurrence of mental health problems. Prevention is crucial in rehabilitation since it gives people responsibility for their health, which is more rewarding and quality-assuring.

◆ *Recovery and prevention*

Rehabilitation and health are paramount for physical, emotional, and social recovery. Rehabilitation helps regain lost capabilities, cope with chronic diseases and mental health problems, and readapt to society. It contributes not only to the immediate results of recovery but also to long-term health and well-being, preventing further complications and enhancing the ability of the individual to lead a whole life. Whether physical, psychological, or even social, rehabilitation must play a significant role in achieving and maintaining overall health. It is crucial in both recovery and prevention.

### **3.4.1.8 Rehabilitation and Society**

The broad contribution of health and rehabilitation towards individuals and society is immense in many ways. Rehabilitation helps one regain health after an illness, injury, or surgery and adjust to society's productive, independent, and socially participative life. Some of the significant emphases with which health and rehabilitation as a profession can be seen to contribute to society are highlighted below:

## 1. Fostering Social Inclusion and Independence

### ◆ *Independence in life*

Rehabilitation assists individuals in gaining independence in life, should they be suffering from complications of physical or mental health. For example, rehabilitation will allow patients who have gone through strokes, accidents, or post-surgical conditions to regain lost abilities in performing daily activities and working and social interactions. Self-sufficiency is related to maintaining dignity and self-respect; one feels they contribute actively to society rather than depend on others and the healthcare system. Mental health rehabilitation allows for the management of conditions such as depression and anxiety, thereby allowing for the resumption of standard social roles and improving interactions with family, friends, and communities.

## 2. Reducing Healthcare Burden

### ◆ *Reduce burden of healthcare resources*

Effective rehabilitation programmes can reduce the long-term need for expensive medical interventions by promoting recovery, preventing complications, and reducing hospital readmissions. For example, rehabilitation after surgeries like joint replacements or bypasses of the heart accelerates the recovery process, reduces risks of complications, and decreases dependence on medical interventions in the long term. This improves the quality of life for individuals and reduces the burden on healthcare systems, saving money while enhancing the effectiveness of healthcare resources.

## 3. Promoting Workforce Participation

Rehabilitation is at the core of enabling a person to return to work or continue with work after falling ill or getting injured. Various programmes for supporting people with disabilities, chronic conditions, or injuries focus on regaining functional abilities and acquiring new skills with adaptation to work. Supporting the workforce, rehabilitation contributes to economic productivity and reduces unemployment rates, allowing workers to maintain financial independence and stability. In this light, rehabilitation means a labour force's healthy and active participation.

## 4. Promoting Preventive Health Habits

Rehabilitation often encompasses health education through which disabled people learn self-management

of chronic conditions, avoiding further deterioration of health and adopting healthier lifestyle behaviours. Patients attending cardiac or diabetes rehabilitation programmes are enlightened on exercises, dietary considerations, and methods of controlling stress to prevent further health complications. By promoting preventive care and self-management, rehabilitation allows them to take responsibility for their health and avoid needing more intensive medical interventions, contributing to public health.

## 5. Fostering Mental Health Awareness and Support

Mental health rehabilitation is assuming immense importance in today's world as the stigma associated with mental health maladies is being increasingly overcome. The prevalence of mental health disorders, such as depression, anxiety, and addiction, affects a huge part of the population, and rehabilitation gives essential support to recovery and reintegration into society. Effective mental health rehabilitation programmes help individuals cope with their conditions, learn coping strategies, and manage their symptoms, reducing stigma and fostering a more compassionate and supportive society. Rehabilitation aims to equip the individual with the skill of rebuilding his emotional and psychological life, thereby improving his social interactions, work life, and contribution to society in general.

◆ *Social interactions*

## 6. Supporting Aging Populations

With many countries facing an ageing population, rehabilitation is vital in keeping elderly adults mobile, cognitively intact, and independent. Geriatric rehabilitation enables older individuals to deal with physical and mental stresses related to ageing, such as impairment of mobility, decline in cognition, and chronic diseases like arthritis. This helps seniors continue living independently and participating actively in their communities, reducing the burden on healthcare systems and long-term care facilities.

◆ *Physical and mental stresses*

## 7. Improving Quality of Life for People with Disabilities

Rehabilitation plays a crucial role in the lives of persons with disabilities, as it allows them to have a better quality of life and be integrated into society. It offers specific

◆ *Community life*

interventions that improve mobility, communication, and cognitive function, enabling individuals to live independently and participate in community life. Rehabilitation for people with physical disabilities or developmental conditions fosters inclusion and equality in various ways, enabling individuals with disabilities to prosper socially, economically, and emotionally.

## 8. Community Well-being Enhancement

Rehabilitation contributes to overall communal well-being by reducing the social isolation associated with illness, injury, or disability. Family involvement in rehabilitation programs, peer support, and community outreach facilitate integration into the community. These enhance relationships and mental health while ensuring that persons feel supported as they navigate their path through recovery. Moreover, as people get well enough to regain independence in life and contribute back to society, rehabilitation helps further a collective sense of well-being and shared responsibility.

- ◆ *Reducing social isolation*

## 9. Decreasing Social Inequality

Therefore, access to rehabilitation services may play a key role in bridging the gap in healthcare disparities. Typically, when low-income or major marginalised groups face barriers to seeking health care, it leads them either to poor health outcomes or prolongs their recovery time. By making such rehabilitation services more accessible, societies can ensure that every individual, irrespective of any socio-economic background, gets an opportunity to recover and regain independence for a fulfilling life. The way rehabilitation helps reduce social inequality and promotes health equity.

- ◆ *Reduce social inequality*

## 10. Improved Public Health

Rehabilitation is essential in public health because it addresses individual or collective needs. Rehabilitation manages chronic conditions, avoids further deterioration of diseases, and reduces the prevalence of long-term disabilities. At the individual level, rehabilitation improves physical, mental, and social health, enhancing the population's health. In this respect, rehabilitation becomes an instrument for promoting public health and reducing the socio-cultural and economic

- ◆ *Collective Needs.*

◆ *Better health infrastructure*

Rehabilitation helps individuals overcome physical, mental, and emotional difficulties and improves their general well-being and quality of life. Accessibility is a significant barrier to rehabilitation, despite its apparent benefits, because of financial, geographical, and systemic challenges. In addition, the shortage of skilled professionals and the social stigma associated with some conditions further complicate the rehabilitation process. Unless these challenges are met with increased funding, better health infrastructure, and more public awareness, these rehabilitation services cannot be accessible and available to all. It is only when such an inclusive and supportive environment for rehabilitation is created that society can help individuals regain their independence and long-term health outcomes.

◆ *Indian population*

According to NSSO 76th Round (2018), about 2.2% of the Indian population lives with some form of disability. Among these, nearly 75% of people in rural areas lack access to institutional rehabilitation services, highlighting major service gaps. Only 21.8% of persons with disabilities report receiving aids or appliances from government or NGOs, showing insufficient outreach and resource provision. NFHS-5 (2019–21) highlights a lack of integration of disability-related indicators in many public health programmes, which limits evidence-based policy-making for rehabilitation services.

The Ayushman Bharat health scheme extends financial coverage for hospital care but currently does not include comprehensive post-hospital rehabilitation or long-term support for disabilities, creating a critical gap in ongoing care.

## Summarised Overview

Rehabilitation is restoring and developing an individual's physical, mental, and social capabilities after an illness, injury, or disability. A wide range of therapeutic interventions is devised to assist the person in improving their functioning and quality of life. The goal of rehabilitation goes beyond the restoration of physical health. It addresses those aspects of recovery that nurture an individual toward independence and integration into society emotionally, psychologically, and socially. Principles of rehabilitation are based on a patient-centred approach in which individualised care and support are projected. Another core principle is early intervention, as the potential for recovery improves when treatment begins soon after injury or illness. The multidisciplinary approach is vital because a team of health professionals, doctors, therapists, and social workers design a

tailored rehabilitation plan. The rehabilitation programmes address physical recovery, psychological well-being, and social reintegration. The patient's active participation in motivation and achievement of long-term goals will also be needed. Most importantly, the key would be to empower them toward independence and quality of life. Equally important are community integration and long-term support systems that help an individual remain adaptive in the environment when formal rehabilitation has been terminated.

## Self-Assessment Questions

1. What is rehabilitation?
2. Define adaptation.
3. How can helping individuals reintegrate into society be described in terms of social support and recovery?
4. What does health and physical functionality restoration through medical interventions involve?
5. Which organisations and institutions play a role in supporting individuals' recovery and reintegration efforts?
6. How do private organisations contribute to the rehabilitation process in society?

## Assignments

1. Explain the importance of rehabilitation.
2. Discuss the importance of assisting individuals in their recovery and reintegration into society.
3. Examine the key principles and foundational concepts that underpin effective rehabilitation practices.
4. Analyse how supporting individuals in navigating new circumstances or challenges can foster adaptation.
5. Evaluate the common challenges faced in providing therapy and supporting rehabilitation efforts.



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2. Albrecht, G. L. & Fitzpatrick, R. (1994). *Quality of Life in Healthcare: Advances in Medical Sociology*. Mumbai: Jai Press.
3. Basu, S.C. (1991). *Handbook of Preventive and Social Medicine*. 2nd Edition. Calcutta: Current Books International.
4. Berkman, L.A. & Kawachi, I. (2000). *A Historical Framework for Social Epidemiology*. London: Oxford University Press.
5. Bhasin, V. (1994). *People, Health and Disease: The Indian Scenario*. Delhi: Kamla Raj Enterprises.



## Space for Learner Engagement for Objective Questions

Learners are encouraged to develop objective questions based on the content in the paragraph as a sign of their comprehension of the content. The Learners may reflect on the recap bullets and relate their understanding with the narrative in order to frame objective questions from the given text. The University expects that 1 - 2 questions are developed for each paragraph. The space given below can be used for listing the questions.

SGOU



# Health Care System and Problems

**BLOCK-04**



## Private and Health Care Services

### Learning Outcomes

On completion of the unit, the learner will be able to:

- ◆ comprehend the concepts of Indigenous Systems of Medicine
- ◆ examine the role of Voluntary Health Services
- ◆ explain the Problems in Health Care Services

### Background

The health care system is one of the backbones of societal development and assurance of people's physical, mental, and social well-being. In most developing countries, including India, healthcare systems are characterised by complex interactions among public and private services, indigenous medical practices, voluntary health services, and systemic challenges. Understanding this framework is important in addressing health access and outcome disparities. Healthcare delivery in most countries runs on a dual system comprising public and private services. The government funds public healthcare systems intending to provide universal health coverage at either minimal or no cost. They concentrate on essential health services, immunisation, maternal and child health, and prevention of diseases. However, they are criticised for underfunding, inadequate infrastructure, and workforce shortages.

On the other hand, private health services are profit-based and thus tend to serve mainly middle- and upper-income populations. They usually have better medical equipment and shorter waiting times but are far less accessible to economically weak groups due to high costs. This dichotomy has led to inequalities in access and quality of care, particularly in rural and marginalised communities. The indigenous systems of medicine, including Ayurveda, Siddha, Unani, and Naturopathy, hold an essential place within the cultural and healthcare landscape of countries like India. These systems are based on holistic and preventive healthcare practices grounded in traditional knowledge. The National Health Policy has recognised them, and most of these are much cheaper and more culturally acceptable in rural areas. Their wider acceptance is, however, inhibited



by the lack of scientific validation, poor integration with modern health services, and lack of information about the benefits they offer. Voluntary health services can be used to extend quality healthcare services to far-reaching areas. The critical services NPOs, charitable trusts, and faith-based organisations provide include health camps, mobile clinics, and community-based interventions. They often fill in the much-needed attention gap that the most neglected health issues, including mental health, chronic diseases, and disabilities, leave open. Challenges, however, would generally arise related to financial instability, depending on external funding, and limits in the scalability of services.

## Keywords

Indigenous medicine, Voluntary health services, Health disparities, Healthcare, Systemic challenges

## Discussion

The healthcare system is an important part of the development of society; however, it has many challenges in delivering equitable and quality services. The duality of healthcare, divided between public and private services, creates a dichotomy in access and quality. Public healthcare services, while affordable and accessible to many, are usually plagued by underfunding, poor infrastructure, and a workforce shortage. On the other hand, private healthcare has high treatment costs and is inaccessible to economically weak groups. These differences have brought about serious health inequities in rural and poor communities. Traditional systems of medicine, like Ayurveda and Siddha, offer culturally relevant and affordable alternatives.

Systemic problems in the healthcare system include inadequate infrastructure, workforce shortages, high care costs, and quality inconsistencies. Another significant barrier is cultural: gender inequities and lack of health literacy. In this case, implementing policies and integrating diverse healthcare approaches will help create an inclusive system. All the above issues are addressed in this unit through a multi-pronged approach, combining investments in public healthcare, regulation of private services, promotion of indigenous medicine, and support for voluntary health

initiatives. The discussion emphasises the need for a comprehensive and collaborative effort to ensure equity and quality of health for all.

The Public Health Service is a group of government-run health centres and hospitals. Every state government has healthcare centres in villages and multi-speciality hospitals in metro cities that provide free or highly subsidised healthcare facilities, such as treating diseases and performing necessary tests, food, and medicine.

The private health sector consists of people and agencies that exclude the national government, which participates in the delivery of health services. It is, therefore, fast gaining importance in a mixed health system. The private health sector, sometimes known as “non-state actors,” consists of all actors outside of government.

#### 4.1.1 Public and Private Healthcare Services

The public organisation in a majority regime must serve people in the name of the government. The focal department of government service is the Department of Well-being. India is an emerging country, and the well-being of the majority can be shown. Well-being is our resistance to disease and injury. Apart from all these diseases, basic well-being processes must treat one's condition to preserve well-being. For instance, a person who consumes contaminated water is ill, although he will most likely not make anyone ill. Daily environments that are not sanitised expose a person to illness. One also needs to contend with psychological states when studying well-being.

◆ *Public medical care*

Data from the *NSSO 75th Round (2017–18)* reveals that 55.3% of hospitalisation cases in rural India and 61.4% in urban India occurred in private hospitals, despite the existence of public facilities. This reliance on private healthcare underscores a broader trend of public sector underutilisation, often due to poor infrastructure, inadequate staffing, and lack of medicines in government hospitals. The *NFHS-5 (2019–21)* further indicates that public sector utilisation for childbirth stood at 52.1% overall, but this dropped to below 35% in many high-poverty states, highlighting inequalities. From a sociological lens, this data reflects the deep stratification in healthcare access, where caste, class, and geographical location mediate whether citizens can rely on public services or are forced into costly private care. The coexistence of public and private systems thus reflects not just institutional dualism but also social inequality.



Public health facilities provide affordable and low-cost healthcare services to familiar individuals. Among the particular issues and features of public health facilities are:

1. **Affordability and Accessibility:** Public health facilities aim to provide healthcare services to all members of the public, irrespective of their financial history. Most such facilities provide lower or subsidised deals that reduce the cost of healthcare for the masses.
2. **Preventive Healthcare:** Preventive healthcare measures are a top priority in public health centres. They lead to awareness by promoting health education, prevention of disease, and identification of health conditions at an early level. Considering preventive treatment, the population benefits from reduced disease burden and improved outcomes.
3. **Inclusive Services:** All forms of services are offered in public health centres to cater to the diverse health needs of the population. They can be primary care, maternal and child care, immunisation, chronic disease management, emergency treatment, etc. The aim is to deliver complete care catering to the diverse health needs of the population.
4. **Population Health Orientation:** Public health facilities utilise a population health orientation, where the health of the overall population is kept as the utmost priority compared to the characteristics of individual patients. They analyse health statistics, identify trends and patterns of health, and create interventions and policies for improving the overall health outcomes of the population.
5. **Health Promotion and Education:** Public health centres conduct health promotion and education to raise awareness of disease conditions, healthy behaviours, and disease prevention. The behavioural health campaigns, workshops, and network outreach programmes will help individuals and the community make the right health decisions.
6. **Fairness and Social Justice:** Public health centres have emphasised social justice and fairness in healthcare. They attempt to reduce health disparities and make healthcare available to all unreachable populations, underserved communities, and vulnerable

enterprises. That entails eliminating every barrier to entry: social, financial, cultural, or geographical.

**7. Collaboration and Partnerships:** They further partner with other stakeholders, including government agencies, non-profit agencies, community-based organisations, and health providers, to support enhanced healthcare delivery. It allows them to effectively combine resources, capabilities, and competencies to manage complex health complications.

**8. Emergency Preparedness and Response:** Emergency preparedness and response are centred on public health facilities. They expand plans and procedures for public health emergencies, natural disasters, and disease outbreaks. Public health facilities coordinate with other agencies and healthcare providers to ensure an active and coordinated emergency response.

Public healthcare facilities have an important role in fostering people's health and well-being, minimising health inequalities, and offering quality healthcare services to everyone. Their preventive focus, accessibility, affordability, and community orientation make them vital to healthcare systems worldwide.

#### 4.1.2 Private Healthcare Facilities

There has also been a rising trend in private medical care offices everywhere in the world because they offer excellent add-on services and thus become the most sought-after ones in contrast to public medical services offices. Private medical care offices are clinics or urgent care facilities that are provided free. Non-profit associations or organisations primarily manage them. Individuals are free to select the office they would prefer to be attended to because all the offices are available. The private medical services offices include mental well-being offices, laboratories, rehabilitation centres, dental offices, optical workplaces and many others.

◆ Private medical care

The increasing dominance of the private health sector in India is substantiated by *NSSO* data, which shows that average out-of-pocket expenditure per hospitalisation in private hospitals is Rs. 31,845, compared to Rs. 4,452 in public hospitals. Despite these exorbitant costs, nearly two-thirds of urban patients opt for private facilities, indicating both a perception of better quality and a failure of the public system to meet expectations. The *National Health Profile (2022)* also reports that around 70% of India's healthcare spending is



private, with 90% of that being out-of-pocket. The economic burden disproportionately affects the poor, leading to medical impoverishment. Sociologically, this trend illustrates the commodification of health, where access depends on one's ability to pay, and where healthcare becomes a site of exclusion rather than inclusion.

### 4.1.3 Indian Systems of Medicine

#### ◆ Traditional healing

The Indian Systems of Medicine, collectively known as AYUSH (Ayurveda, Yoga, Unani, Siddha, and Homoeopathy), are crucial in shaping India's healthcare landscape through a sociological lens. These traditional healing practices are deeply embedded in cultural and historical narratives, influencing not only medical approaches but also societal norms, beliefs, and accessibility to healthcare. AYUSH has long been a preferred choice for individuals seeking holistic, affordable, and community-based treatments, especially in rural and economically disadvantaged areas where modern medical infrastructure is limited. The widespread social acceptance of AYUSH is rooted in generational trust, local knowledge, and its integration into daily life.

#### ◆ Formal medical care

However, despite its relevance, these indigenous systems often face challenges in scientific validation, policy implementation, and institutional support, which affect their credibility within formal medical frameworks. The government has increasingly invested in promoting AYUSH by setting up educational institutions, standardising practices, and encouraging research, signalling a shift toward medical pluralism that embraces both traditional and modern medicine. According to data from the *Ministry of AYUSH (2022)*, there are over 8 lakh registered AYUSH practitioners and approximately 3,500 AYUSH hospitals across India. While this indicates growing institutional recognition, AYUSH facilities still receive only around 3.5% of the national health budget. The *NFHS-5* suggests that less than 10% of the population primarily seeks care from AYUSH practitioners, although trust in these systems remains high in certain rural and tribal communities.

#### ◆ Biomedical system

This discrepancy reveals a state preference for biomedical systems and illustrates Foucault's critique of how state power and institutional legitimacy are often granted to certain knowledge systems over others. From a sociological standpoint, the marginalisation of traditional medicine

also represents a postcolonial erasure of indigenous health practices and underscores urban-biased policy development.

### a. Ayurveda

#### ◆ Create health

Ayurveda, a Sanskrit word meaning “the science of life,” is one of the oldest holistic healing systems, born over 3,000 years ago in India. Its origins are based upon ancient Vedic texts, wherein this healing modality aspires to balance the mind, body, and spirit to create health and prevent disease. This system is based on the unity of the three doshas: Vata, air and space; Pitta, fire and water; and Kapha, earth and water. According to Ayurveda, when these doshas become imbalanced, one develops a disease, but their balance creates health and wellness.

#### ◆ Science of life

Ayurveda advocates for personalised care, and it believes that each human entity has a different constitution called “Prakriti,” which explains the characteristics of the individual, whether physical, mental, or emotional. The treatments are directed towards allowing the restoration of their Doshas through various forms of treatment using natural remedies, dietary advice and prescriptions, detoxification therapies, and advice on lifestyle modification.



Figure 4.1.1 Ayurveda

Ayurveda’s contemporary appeal stems from its integration into global wellness culture, where it is reimagined not merely as traditional medicine but as a lifestyle solution to chronic illnesses, stress, and lifestyle disorders. As Madhulika Banerjee (2002) argues, this shift often involves fragmenting Ayurvedic knowledge to fit biomedical frameworks, privileging scientifically validated aspects like herbal efficacy and diet while sidelining holistic ontologies. Leena Abraham (2009) further notes how Ayurvedic practices are selectively

appropriated into elite wellness regimes spas, retreats, and herbal products thus detaching them from their socio-cultural contexts. This commodification renders Ayurveda accessible primarily to urban and global consumers, transforming it from a community-based practice into a market-driven wellness brand. While modern research supports aspects of Ayurveda, its popularization risks reducing a rich epistemic tradition into curated experiences. Hence, Ayurveda's revival reflects broader dynamics of neoliberal health, raising concerns about authenticity, access, and the politics of traditional knowledge in contemporary healthcare.

### b. Siddha

Siddha medicine is one of the oldest traditional systems, hailing from Tamil Nadu, India. It is originally from Dravidian culture and has been practised since at least 2,000 years ago. "Siddha" originates from "Siddhi," which means attainment or perfection, symbolizing the system's aspiration to achieve physical, mental, and spiritual well-being. Siddha medicine is attributed to the ancient Siddhars, who were enlightened souls supposed to possess knowledge about medicine, alchemy, and spirituality. Philosophy and principles the Siddha system of medicine is oriented around the concept of balance between the five elements: water, fire, air, and which the human body and the universe are composed of. It is close to Ayurveda in stressing three elemental humours or "Mukuttam": Vatham-air and space, Pitham-fire and water, and Kapham-earth and water. It is claimed that imbalances of these cause diseases. The Siddha system of medicine also recognizes the holistic approach by attending to the body, mind, and spirit to attain health and harmony.

#### ◆ Oldest Medicine

Sujatha (2011) highlights how Siddha medicine emphasizes individualized care, prescribing diet and lifestyle practices based on one's body constitution (*udal thodam*) and disease nature. It integrates daily routines (*naal ozhukkam*) and seasonal regimens (*kaalam ozhukkam*) for preventive health. The personalization distinguishes Siddha from standardized biomedical approaches. Health is seen as a balance between internal humors and external rhythms. Dietary guidance is tailored, not generic, reflecting deep ecological and bodily awareness. Siddha, like Ayurveda, is being reshaped by modern wellness markets. Yet, its core remains rooted in holistic, contextual care.

#### ◆ Contextual care

### c. Unani

#### ◆ Ancient healing systems

Unani medicine, also called Unani Tibb, is one of the ancient healing systems originating in ancient Greece and later being refined by the physicists of Persia and Arabs. The word “Unani” is derived from the Arabic word meaning “Greek” since its origin was laid upon the medical philosophies of Hippocrates and Galen. Further refinement of the system was done by Islamic scholars like Avicenna (Ibn Sina), whose works were seminal, integrating Greek philosophy with new medical insights. Persian and Mughal rulers brought this medicine system into India, one of the country’s mainstays of traditional health care.

#### ◆ Six essential factors

The treatment modality of Unani medicine is based on the theory of Tibb-e-Unani, which considers balance in all four humours: Dam (blood), Balgham (phlegm), Safra (yellow bile), and Sauda (black bile). Health is the state of balance, whereas an imbalance is believed to cause disease. The basis of Unani medicine is attributed to the Six Essential Factors of Life (Asbab-e-Sitta Zarooriya), which include air, food and drink, sleep and wakefulness, physical movement and rest, mental activity and rest, and excretion and retention. The preservation of these factors is important and believed to be essential to maintaining health.

#### ◆ Respiratory conditions

Unani medicine is exceptionally efficient in treating chronic diseases, including arthritis, digestive disorders, skin diseases, and respiratory conditions. The idea of health in Unani, which emphasizes lifestyle and diet, is in tune with the latest trends in preventive medicine. The natural remedies and non-invasive techniques this system offers are equally impressive to many

### d. Homeopathy and Naturopathy

Homeopathy and Naturopathy, though brought to India by European travellers, got established in India with wide public acceptance.

#### ◆ Various symptoms

Homeopathy is an alternative medical practice that uses highly diluted natural substances to treat various ailments. Also known as homoeopathic medicine, it was developed in Germany over 200 years ago. Homeopathic treatments are highly personalized, with no standardized prescribing method for practitioners. Hundreds of homoeopathic remedies are available in different dilutions to address various symptoms.



◆ *Public acceptance*

The holistic approach of homoeopathy focuses on treating each individual as unique, considering their body, mind, emotions, and spirit to manage and prevent disease. Based on an individual's specific symptoms and overall health, a homoeopath selects the most suitable medicine to stimulate the body's natural healing ability. Homeopathic medicines are generally safe and rarely cause side effects. When used appropriately under the guidance of a qualified homoeopath, they are safe for people of all ages, including babies, children, and pregnant or breastfeeding women.

◆ *Lifestyle changes*

Naturopathy is a holistic system of medicine that emphasizes the body's innate ability to heal itself using natural therapies and lifestyle changes. Rooted in traditional European healing systems, it was introduced to India by European practitioners but gained significant popularity due to its alignment with ancient Indian wellness philosophies such as Ayurveda and Yoga. Naturopathy advocates for a drugless approach, relying on treatments like fasting, a balanced diet, hydrotherapy, mud therapy, massage, and regular exercise to maintain and restore health. Over time, it found wide public acceptance in India, especially as a means of preventive healthcare and wellness, and today forms an integral part of the country's traditional healthcare system.

◆ *Sociological perspective*

#### 4.1.4 Voluntary Health Services

Voluntary health services play a crucial role in shaping community health from a sociological perspective, acting as both a complement and a challenge to state-driven healthcare efforts. These agencies operate autonomously, supported primarily through private funding, allowing them to address healthcare gaps that government programs may struggle to fill due to financial or bureaucratic limitations. **Sociologically**, they embody collective action where individuals and communities unite to improve public health, often driven by social responsibility rather than profit motives. Their role in supplementing government healthcare services highlights the importance of social welfare and grassroots mobilization, ensuring that underserved populations receive necessary medical attention.

Voluntary health organizations (VHOs) play a crucial role in filling service gaps, especially in under-resourced areas. According to the *NITI Aayog's 2021 report on NGO participation in health*, over 3,000 NGOs operate in the healthcare sector in India, offering services ranging from

◆ *Improve public health*

primary care to awareness and advocacy. These organizations are particularly active in disaster relief, maternal health, HIV/AIDS prevention, and tribal health. For instance, in Odisha, NGO-led interventions increased maternal health service utilization by 38% in targeted districts. The data supports Robert Putnam's social capital theory showing that community networks, mutual trust, and local engagement can improve health outcomes in ways formal institutions alone cannot. However, it also reflects the retreat of the state from its public health responsibilities.

◆ *Voluntary health agencies*

Beyond service delivery, voluntary health agencies contribute to pioneering advancements by engaging in research and piloting new health initiatives, which governments later adopt on a larger scale. The dynamic between civil society and state institutions where social movements and non-governmental efforts push policymakers toward progressive healthcare reforms, such as family planning programs in India illustrates this synergy. Also, these organizations function as agents of health education, expanding awareness of disease prevention and wellness in ways that government resources alone may not achieve. Their ability to create demonstration models, such as sanitation projects, exemplifies social learning, wherein communities adopt and adapt new practices based on firsthand exposure.

Moreover, voluntary health agencies serve as watchdogs, monitoring and critiquing government policies ensuring public accountability in healthcare administration. Their advocacy work in health legislation demonstrates citizen participation in governance, reinforcing that public health is not solely the state's responsibility but a shared concern requiring community engagement and activism. These agencies shape healthcare discourse by mobilizing public opinion and influencing policy decisions, making healthcare more democratic and accessible.

◆ *Social change*

In essence, voluntary health services illustrate the intersection between health, society, and governance, reinforcing the need for collaborative, multi-social approaches in delivering healthcare. They reflect the broader sociological themes of empowerment, social change, and institutional collaboration, vital in creating a more inclusive and responsive health system. Their continued evolution will depend on sustained public support, policy alignment, and the ability to bridge traditional healthcare practices with modern medical advancements.

#### 4.1.4.1 World Health Organization

World Health Organization is a United Nations specialized agency established in 1948 to attain the highest possible level of health for every citizen in the world. Having headquarters in Geneva, Switzerland, WHO has become the leader in international public health by directing and coordinating global health matters, setting standards for health, and offering technical support to countries in need. The scope of its work encompasses infectious and non-communicable diseases, environmental health, and strengthening health systems. The central mission of the WHO is to promote and protect the health of all people worldwide through the leadership of health policy by well-documented evidence, leading in health emergencies, and promoting fairness regarding health and access to health care within the world's

- ◆ *Health for Everyone*

Universal health care (UHC) is a system where all individuals can access essential health services without financial hardship. It ensures that healthcare is available to everyone, regardless of their economic status, social background, or geographic location. UHC aims to provide equitable healthcare, reduce disparities, and improve overall public health outcomes.

- ◆ *Empower health systems*

Ensure UHC, in which all people will receive quality health services regardless of their socio-economic status. Also, ensure response to global health challenges: infectious diseases, such as HIV/AIDS, tuberculosis, and malaria; non-communicable diseases, such as diabetes, cancers, and heart diseases; promotion of healthy lifestyles and prevention of various diseases through campaigns and public health initiatives. Responses to health emergencies should involve “providing immediate medical care to save lives and long-term recovery strategies following pandemics and natural disasters. Empower health systems the world over with improved infrastructure, better-trained health professionals, and enhanced technologies for health improvement.

#### 4.1.5 Voluntary Health Association of India (VHAI)

Voluntary Health Association of India is a non-profit, registered society formed in the year 1970. It is a federation of 24 state voluntary health associations, linking more than 4000 healthcare institutions and grassroots community health programs nationwide. The primary objective is to make health a reality for the people of India by promoting community health, social justice, and human rights related

◆ *Grassroot level*

to providing and distributing health services. VHAI tries to achieve these goals through campaigns, policy research and advocacy, need-based training, media, parliament interventions, publications and audio-visuals, information dissemination, and health and development projects running in some problematic areas. VHAI walks for people-centred policies and their practical implementation. It sensitizes the general public to important health and development issues for the evolving sustainable health movement in the country, emphasising its rich health and cultural heritage.

◆ *Non profit*

The Voluntary Health Association of India (VHAI), a pioneer among VHOs, reaches over 30 million people through its network of affiliates in 23 states. According to its 2020 annual report, VHAI's tuberculosis intervention programs led to a 22% increase in treatment adherence in low-income communities of Bihar and Jharkhand. Through community health workers and participatory models, VHAI bridges the gap between marginalized populations and formal healthcare providers. Its data-rich models show that interventions based on trust and local knowledge are more effective in health promotion. From a sociological perspective, VHAI's approach underscores the role of participatory governance and civil society in democratizing healthcare and addressing social determinants of health like education, nutrition, and gender.

**a. Indian Red Cross Society**

◆ *Health and wellbeing*

The Indian Red Cross Society is the premier humanitarian organization in India that tries to bring immediate succour during calamities and helps promote health and well-being among the people in the community. It was established in 1920 under the Indian Red Cross Society Act to operate as an autonomous organization and part of the International Red Cross and Red Crescent Movement. The IRCS works guided by the Fundamental Principles of humanity: impartiality, neutrality, independence, voluntary service, unity, and universality. It is noteworthy in disaster management, health services, and community outreach programs.

◆ *Quick responses*

The essential commitment of the Indian Red Cross Society is 'to prevent and alleviate human sufferings without any discrimination'. Its objectives are to provide immediate relief to the people affected by natural and artificial disasters, promote public health activities, mobilize blood donation drives, and develop preparedness in the community for



disasters. It also looks toward improving the quality of life of vulnerable groups such as women, children, the elderly, and persons with disabilities.

#### **b. Hind Kusht Nivaran Sangh (Indian Leprosy Association)**

##### ◆ *Eliminate leprosy*

The Hind Kusht Nivaran Sangh, also commonly called the Indian Leprosy Association, is a non-governmental organization dedicated to eradicating the problem of leprosy and ensuring the well-being of those afflicted with the disease. In the year 1950, the organization emerged at a time when leprosy was an avowedly stigmatized disease, and the facilities to treat it were limited. It has played a critical role in raising awareness, reducing stigma, and promoting early diagnosis and treatment to eliminate leprosy as a public health problem in India.

##### ◆ *Social reintegration*

The primary mission of The Hind Kusht Nivaran Sangh is to control and eventually eradicate leprosy in India while taking care of the rights and dignity concerns of the people suffering from the disease. Its objectives include Promoting public awareness about leprosy and reducing stigma and discrimination in early detection and treatment to avoid deformities and disabilities. Rehabilitation and social reintegration of those affected by leprosy. Collaborating with local governments and other international associations to implement effective leprosy control programs.

##### ◆ *Rehabilitation techniques*

A majority of the rural and backward areas still have a lack of awareness regarding free treatment. There is a need for more trained health professionals and infrastructure in remote areas. Hind Kusht Nivaran Sangh efforts have paid off in reducing the prevalence of leprosy in India. Its campaigns brought leprosy into national focus, ensured policy reforms, and increased funding for its control programs. It also focuses on rehabilitation and advocates for many persons affected by leprosy to regain dignity and restart life.

#### **c. Indian Council for Child Welfare (ICCW)**

Indian Council for Child Welfare is a voluntary organization working for the development of disadvantaged children in child rights issues like child labour, female infanticide, child abuse, early childhood care and education through direct intervention programmes with children's training, advocacy, and action-oriented research. The council was established in 1952. It is affiliated with the International Union for Child Welfare. Since its formation, the ICCW has built a nationwide

◆ *Development of disadvantaged children*

network of state and district councils. The services are devoted to securing those opportunities and facilities for Indian children, by law and other necessary means, to enable them to develop physically, mentally, morally, spiritually, and socially in a healthy and normal manner and with conditions of freedom and dignity.

#### **d. Tuberculosis Association of India**

◆ *Eliminate the disease*

The Tuberculosis Association of India is one of India's most accomplished nongovernmental organizations dedicated to TB eradication. Founded in 1939, this organization resulted from increasing awareness about battling one of the most pervasive infectious diseases afflicting India. The organization was initiated with the vision to eradicate tuberculosis, a century-long fight against the significant public health concern of the country. These years, it has played an important role in TB control programs and continues to contribute to national efforts to eliminate the disease.

◆ *Eventual eradication*

The mission of the Tuberculosis Association of India is to create a world free of tuberculosis, where no Indian dies of TB or suffers from its debilitating effects. Educating the public about tuberculosis prevention, early detection, and treatment. Supporting the government's National TB Control Programme through participating in awareness creation and offering technical support. Advocating for better health policies and increased resources to fight TB. Providing care and support for people affected by TB, including drug-resistant forms of the disease. Promoting research in the diagnosis, treatment, and prevention strategies for TB. Activities and Contributions TAI have performed the following in various activities for the control and eventual eradication of tuberculosis:

### **4.1.6 Problems in Healthcare Services**

#### **1. Accessibility Issues**

One of the most significant problems in healthcare services is unequal access to care, particularly in rural and underserved areas. While urban centres may have better healthcare infrastructure and more medical professionals, rural areas often face shortages of doctors, hospitals, and medical facilities. This disparity leads to a higher incidence of untreated conditions and delayed diagnoses, especially for low-income communities. In many countries, especially in developing parts of the world, people cannot access health



services due to distance problems, lack of transport, and poor public health facilities.

◆ *Better healthcare*

Although policy commitments, serious problems persist in India's health system. *NFHS-5* highlights major regional disparities in health outcomes: while states like Kerala have an infant mortality rate (IMR) of 6 per 1,000 live births, Bihar and Uttar Pradesh report IMRs of 32 and 41 respectively. Additionally, the *NSSO* shows that 20% of rural households forego medical treatment due to financial constraints. Lack of insurance coverage, distance from healthcare facilities, and inadequate public expenditure (just 2.1% of GDP as per the *Economic Survey 2023*) continue to hamper service delivery. These statistics reflect structural inequalities that mirror the broader socio-economic stratification in Indian society. From a sociological standpoint, the health system's problems are not merely technical or logistical they are deeply rooted in class, caste, gender, and spatial inequalities that require structural policy responses.

## 2. High Costs and Financial Barriers

◆ *Direct and indirect costs*

Health care costs remain another big problem; direct and indirect costs of health care services are higher. People with middle and low-income status barely bear the increased cost of medical treatments, hospital admissions, and prescription drugs. In countries lacking universal health coverage, private healthcare providers charge excessively high costs that become burdensome to the household or must be foregone. In countries with different forms of health insurance, out-of-pocket expenditure on health remains very high, and many face considerable debt due to medical bills. A financial burden often is a significant obstacle to timely and sufficient health care.

## 3. Inequality in Health Care Delivery

◆ *Inequality in healthcare*

Many healthcare systems are often characterized by inequality in the level of care between different groups in society. This may manifest as disparities in care by socioeconomic status, gender, race, and geographic location. In several parts of the world, the care accorded to marginalized groups, such as ethnic minorities and people of lower socioeconomic status, is either inadequate or even discriminatory. Inequity in healthcare provision may exacerbate existing health inequities, making services inaccessible to all groups of the population equitably.

#### 4. Shortage of Healthcare Professionals

◆ *Health outcomes*

A shortage of qualified healthcare professionals, particularly physicians, nurses, and medical technicians, is another chronic problem faced by many healthcare systems. This is particularly acute in rural and underserved areas, as internal migration to urban centres has resulted in understaffing in most parts. The shortage of personnel impairs the mode of delivery of health services, while the few health workers there are overworked to exhaustion. This snowballs the quality of care provided, and longer waiting times for patients subsequently diminish their health outcomes.

#### 5. Fragmentation and Inefficiency in Health Care Systems

◆ *Integration of service*

Many healthcare systems exhibit fragmentation, typified by poor coordination of services between providers and sectors. This leads to inefficiencies, where duplicated tests can occur, referrals might be delayed, and there can be a lack of communication between specialists. This fragmentation in health usually results in poor patient experiences, lack of coordination, and increased costs. Inadequate integration of the services between primary, secondary, and tertiary levels can raise several patient barriers while navigating the complex healthcare delivery system.

#### 6. Poor Health Infrastructure

◆ *Insufficient hospitals*

Poor health infrastructure remains one of the most important problems in large parts of the world, especially in developing countries. This includes insufficient hospitals, poor medical equipment, and the unavailability of essential medicines. Poor sanitation and personal hygiene in health centres enhance the rate of infections, hence becoming hazardous to the patients. The absence of modern diagnostic apparatus and treatment facilities means the scope of healthcare is limited to minimum dimensions. Most developing-country governments cannot afford to invest adequately in developing their healthcare infrastructure, which slows the quality service delivery rate.

#### 7. Mental Health Issues and Lack of Support

Mental health services are often neglected within healthcare systems, resulting in inadequate care for individuals suffering from mental health disorders. Many healthcare



◆ *Mental health disorder*

systems do not provide enough resources for mental health professionals, leading to long wait times and insufficient treatment options. The stigma surrounding mental illness further exacerbates the problem, as many individuals are reluctant to seek help. Often, mental health is pushed to the backseat, and because of this lack of wholeness in mental health care, conditions tend to worsen, and overall health outcomes deteriorate.

## 8. Medical Errors and Concerns for Patient Safety

◆ *Illness and death*

Medical errors in healthcare services include misdiagnosis, medication mishaps, and surgical errors; these are a grave concern in various parts of the world. These further cause harm to patients and prolong their illness and death. These are caused by poor training, poor staffing, and impaired communication among the health teams. Again, the absence of substantial patient safety protocols and mechanisms to monitor and take proper measures against each error makes this threat even more probable. The safety of the patients lingers as a critical concern that necessitates improvements in healthcare training, technology, and oversight.

## 9. Crises in Public Health and Emergencies

◆ *Public health emergencies*

Public health crises that include pandemics, natural disasters, and infectious disease outbreaks are standard features of our world. These inadequacies of global healthcare systems, highlighted by the COVID-19 pandemic, include preparations for this kind of virus, insufficient testing, tracing contacts poorly, and PPE shortages. In these crises, health services become overwhelmed, leading to the rationing of care, burnout of health workers, and an increase in preventable deaths. The inability to promptly and effectively respond to public health emergencies underlines the need for resilient and adaptable health systems.

## 10. Aging Populations and Increased Demand for Care

◆ *Long term care*

As life expectancy increases globally, many countries are increasingly facing an ageing population that puts an added burden on healthcare systems. Older adults have several comorbid chronic conditions that need long-term care, special treatment, and frequent medical check-ups. Increased incidence of age-related diseases like dementia, arthritis, and cardiovascular diseases brings stressors on healthcare

service utilization, which has created a daunting task to treat all older adults with equal precedence. A shortage of resources, health professionals, and infrastructure in meeting these demands adds to the problem.

**Public vs. Private Health Care in India** Rama V. Baru's seminal work highlights the growing commercialization and dominance of the private sector in India's healthcare landscape, often at the cost of equitable access. She critiques the state's retreat from its public health responsibilities and the resultant deepening of social inequities in health access and outcomes. Baru underscores how the private sector caters predominantly to the urban middle and upper classes, while the public sector underfunded and overstretched serves the poor. Her analysis reveals how this dual system leads to fragmented care, increased out-of-pocket expenditure, and limited accountability in health service delivery.

## Summarised Overview

The coexistence of public and private healthcare systems brings out the duality in the approach to healthcare delivery. The government's financed and administered public healthcare services should provide universal access to essential health services, including immunization programs, maternal and child health services, and primary healthcare. However, public facilities often face inadequate funding, archaic infrastructure, and workforce shortages that lower effectiveness. On the other hand, private health services, though offering high technology and specialized care, cater to the affluent class, leaving the economically weaker sections underserved because of the high cost of treatment. This disparity between the public and private systems underlines the dire need for better resource allocation and regulation. Indigenous medicine, such as Ayurveda, Unani, Siddha, and homoeopathy, occupies a unique place in health care, especially in culturally rich countries like India. They emphasize holistic well-being, preventive care, and natural treatments; thus, they are relatively inexpensive and accessible to many rural populations. While these practices hold great promise, they are also quite limited by their lack of rigorous scientific validation, low research funding, and poor integration into mainstream health care. More investment in research and education about these traditional systems can enhance their role in addressing health challenges, especially where modern medicine is not within reach.



## Self-Assessment Questions

1. Describe the key characteristics of private health care services.
2. Examine how systems of medicine based on natural remedies and spiritual healing operate.
3. Analyze the primary challenges faced by the public health care system.
4. Discuss indigenous systems of medicine with appropriate examples.
5. Explain the primary objectives of voluntary health services.
6. Discuss the significant challenges confronting indigenous systems of medicine.
7. Describe the major features that define public health care services.
8. Examine the various factors that contribute to the problems in health care services.

## Assignments

1. Discuss the contributions of the Voluntary Health Association of India to public health services in the country.
2. Examine the key principles and historical development of Traditional Chinese Medicine.
3. Describe the major missions and objectives of the Indian Red Cross Society in promoting health and humanitarian work.
4. Analyze the difference between diagnosis and treatment, and explain their significance in patient care.
5. Explain the role of the World Health Organization (WHO) in addressing global health challenges.

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## Suggested Reading

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## Space for Learner Engagement for Objective Questions

Learners are encouraged to develop objective questions based on the content in the paragraph as a sign of their comprehension of the content. The Learners may reflect on the recap bullets and relate their understanding with the narrative in order to frame objective questions from the given text. The University expects that 1 - 2 questions are developed for each paragraph. The space given below can be used for listing the questions.

SGOU



# UNIT 2

## National Health Programs

### Learning Outcomes

On completion of the unit, the learner will be able to:

- ◆ explain the National Health Programmes in India
- ◆ analyse the Health Care Delivery Systems in India
- ◆ discuss the concept of NRHM and National Health Policy

### Background

A general knowledge of the various public health issues that face India is, therefore, helpful in an appropriate understanding of the National Health Programmes. This implies knowledge of problems such as communicable diseases, maternal and child health, malnutrition, and the increasing burden of non-communicable diseases. In this regard, knowledge about the government's initiatives implemented in response to RNTCP (Revised National Tuberculosis Control Programme), NACP (National AIDS Control Programme), and immunization schemes, among others, becomes important. Moreover, knowing the goals, strategies for implementation, and evaluation methods of such programs becomes indispensable in ascertaining the performance of the programs in delivering solutions to public health problems. A more excellent analysis of India's healthcare delivery systems requires knowing its multi-tiered nature. The system has public and private sectors with formal and informal healthcare providers. A pre-requisite for such an analysis would be knowledge of the roles and responsibilities of different stakeholders like the Ministry of Health and Family Welfare, state health departments and local government bodies. There also needs to be awareness of PPPs' (Public-Private Partnerships) contributions towards health care delivery for an in-depth system evaluation.

The Indian health care system works in three levels: primary, secondary, and tertiary care. Most of these are understood by their unique characteristics, functions, and interdependencies. The health sector in primary care is concerned with preventing diseases and provides essential health services at sub-centres

and primary health centres (PHCs). The district hospitals and community health centres provide secondary care for more specialized treatment. Tertiary care entails more sophisticated and specialized treatment facilities, including super-speciality hospitals. Knowledge of each level's services, staffing, and infrastructure is important for assessing their effectiveness and integration. The National Rural Health Mission, started in 2005, significantly strengthens rural health care through better access, quality, and equity. Understanding the goals and key initiatives such as ASHAs (Accredited Social Health Activists) and their impact on rural health outcomes is necessary. On the other hand, studying the NHP (National Health Policy) gives insight into the government's long-term vision of achieving universal health coverage and reducing health inequity. Understanding the policy's provisions, goals, and strategies is fundamental to assessing its influence on India's healthcare landscape.

Over the years, India's public health initiatives have evolved to address changing healthcare needs and improve access and quality of services. The National Rural Health Mission (NRHM), launched in 2005, was a landmark program aimed specifically at strengthening healthcare delivery in rural areas, focusing on maternal and child health, immunization, and infrastructure development. Recognizing the need for a more integrated approach beyond rural settings, the NRHM was subsumed into the National Health Mission (NHM) in 2013, which combined both rural and urban health programs under a unified framework. The NHM aimed to provide comprehensive health coverage with enhanced focus on disease control, non-communicable diseases, and systemic health reforms. Recently, to further streamline and emphasize holistic health service delivery, the government renamed the program as Pradhan Mantri Samagra Swasthya Mission (PM-SSM). This rebranding reflects a broader vision toward integrated health systems that prioritize accessibility, quality, and equity across the country, uniting various health programs under a single umbrella for better coordination and impact.

## Keywords

NHM'ASHA'Public health care, Health policy, Vaccination

## Discussion

### ◆ Significant challenges

The public health system in India still faces the significant challenges of communicable diseases, maternal and child health, and malnutrition while being overtaken by an increasing burden of non-communicable diseases. The National programs of RNTCP, NACP, and immunization schemes have been indispensable in addressing some of the preceding concerns. Such programs aim to understand the goal, implementation strategies, and evaluation mechanisms implemented toward achieving the desired outcome in lessening public health challenges. It has also been observed that the healthcare delivery system functions under the multi-tiered framework in India primary, secondary, and tertiary, each with a distinct role. While primary care deals with the prevention of diseases and essential health services, secondary and tertiary care involve specialized and advanced treatments, respectively.

### ◆ Long-term vision

Public private partnerships further improve healthcare delivery through better pooling of resources and expertise. Since its inception in 2005, the National Rural Health Mission has been instrumental in strengthening rural health by improving access, quality, and equity through initiatives like Accredited Social Health Activists (ASHAs). At the same time, the National Health Policy sets a long-term vision for achieving universal health coverage and reducing health inequities. Knowledge of who the major stakeholders are be it the Ministry of Health and Family Welfare, state health departments, or local governing bodies is necessary for gauging performance. From this interplay of factors analyzed, one could realise the challenges and opportunities concerning the healthcare system in India and bring coordinated efforts to achieve equitable and accessible healthcare for all.

### ◆ Health outcomes

India has implemented several national health programs to address significant health problems and improve health outcomes among its public. These programs have addressed many areas: maternal and child health, infectious diseases, non-communicable diseases, and health system strengthening. Accordingly, through the Ministry of Health and Family Welfare, the government is coordinating and

### 4.2.1 National Health Programmes



monitoring these programmes to meet the health care requirements of its people.

◆ *Immunisation coverage*

The Government of India runs several key national health programmes, including the National Tuberculosis Elimination Programme, the Universal Immunization Programme, and the National Programme for Control of Blindness. These are designed to address major public health concerns. However, data from NFHS-5 (2019–21) reveal uneven progress: for example, full immunisation coverage among children is 76.4% nationally, but only 62% in Bihar and 57% in Nagaland. Antenatal care (4 or more visits) is accessed by 97% of pregnant women in Kerala but only 42% in Bihar. While national health programs are widespread, their efficacy is inconsistent across states due to infrastructural and socio-economic variations. From a functionalist perspective, national health programmes maintain the equilibrium of society by ensuring the health and productivity of its members.

Some of the significant national health programmes of India are as follows:

### 1. National Tuberculosis Elimination Programme

◆ *Management and control*

The National Tuberculosis Elimination Programme (NTEP) was initially launched as the Revised National Tuberculosis Control Programme (RNTCP) in 1997. It was initiated to strengthen the efforts against tuberculosis, a significant public health challenge in India. Over time, the program evolved with enhanced strategies aimed at early detection, free treatment, and ensuring patients complete their course of medication. The program's primary goal is to eliminate TB as a public health problem in the country. It was renamed NTEP in recent years to reflect its ambitious target of ending tuberculosis by 2025. The program has continuously adopted advanced technologies, including the GeneXpert diagnostic tool for rapid and accurate TB detection, especially drug-resistant forms, while also working to reduce stigma and build healthcare capacity for effective TB control.

### 2. National Health Mission (NHM)

The National Health Mission (NHM), launched in 2013, represents a significant transformation in India's public health system by integrating two previously separate programs: the

- ◆ *To improve access to healthcare*

National Rural Health Mission (NRHM), started in 2005, and the National Urban Health Mission (NUHM). This integration created a unified framework to improve healthcare access and outcomes across both rural and urban areas. NHM focuses on reducing maternal and child mortality, expanding access to essential health services, strengthening health infrastructure, and raising health awareness among the population. The inclusion of the National Urban Health Mission within NHM specifically targets vulnerable urban populations, such as those living in slums, ensuring a more comprehensive and equitable approach to public health in India.

### 3. Universal Immunization Program (UIP)

- ◆ *Advance in Vaccine*

The Universal Immunization Program (UIP) was launched in 1985 by the Government of India as a flagship public health initiative aimed at protecting children and pregnant women from vaccine-preventable diseases. It is one of the largest immunization programs globally, designed to ensure every child receives vaccines according to the national immunization schedule. Initially, the program focused on six major diseases: poliomyelitis, diphtheria, pertussis (whooping cough), tetanus, tuberculosis, and measles. Over the years, UIP has expanded its coverage to include vaccines for hepatitis B, rubella, Japanese encephalitis, rotavirus, pneumococcal infections, and others, reflecting the evolving disease burden and advances in vaccine technology.

- ◆ *Public Health Effort*

UIP's primary goal is to reduce infant and child mortality rates by preventing the occurrence and spread of infectious diseases among vulnerable populations, especially in economically disadvantaged and hard-to-reach areas. The program prioritises universal access and equity, ensuring immunisation services reach children across rural, urban, and tribal regions. This massive public health effort is implemented through a vast network of government healthcare facilities, frontline health workers such as Accredited Social Health Activists (ASHAs), Auxiliary Nurse Midwives (ANMs), and Anganwadi centers.

- ◆ *Polio Free*

The impact of UIP has been substantial. The program has played a critical role in eradicating poliomyelitis from India, which was declared polio-free in 2014. It has also contributed significantly to the reduction of morbidity and mortality from other vaccine-preventable diseases, thereby improving child survival rates and overall community health. Furthermore, UIP has enhanced awareness and acceptance of vaccination,



combating vaccine hesitancy through public education campaigns.

- ◆ *Reducing mortality among children*

The continuous strengthening of UIP, including introduction of newer vaccines and improved cold chain logistics, demonstrates India's commitment to safeguarding public health. The program remains a cornerstone of the country's child health strategy and an essential component of the broader National Health Mission framework, reinforcing the government's dedication to equitable, accessible, and sustainable healthcare.

#### 4. National AIDS Control Program (NACP)

- ◆ *Counselling Treatment*

The National AIDS Control Program was started in the year 1992 to contain the spread of HIV/AIDS and the stigma and discrimination associated with the infection. It provides free of cost testing, counselling, treatment, and prevention services for HIV. It is focused on creating awareness, especially among the high-risk groups that include men who have sex with men, sex workers, and intravenous drug users. NACP has been instrumental in bringing down new infections and putting people living with HIV on Antiretroviral Therapy

#### 5. National Family Planning Program (NFPP)

- ◆ *Social Development*

The National Family Planning Program (NFPP) in India was officially launched in 1952, making it one of the earliest government initiatives to control population growth and promote reproductive health. The program was initiated as part of India's broader public health strategy post-independence, responding to the challenges posed by rapid population increase and its impact on economic and social development. The NFPP aimed to provide widespread access to family planning services, including contraceptive methods and sterilization procedures, to help couples plan their families and improve maternal and child health outcomes.

- ◆ *Family Planning Options*

Initially, the program focused on promoting awareness of family planning methods and encouraging voluntary acceptance of contraception. Over the decades, the NFPP evolved to emphasise a more comprehensive approach to reproductive health, integrating maternal and infant health services and addressing issues such as infant and maternal mortality. The program prioritised women's health by improving access to affordable and effective family planning options and involving men in reproductive health education.

◆ *Counselling*

The NFPP has been implemented through a network of public health facilities and community outreach programs, with frontline workers playing a crucial role in counselling and service delivery. Despite challenges such as cultural barriers, misinformation, and uneven access, the program contributed significantly to reducing fertility rates and improving health indicators across the country.

◆ *Control population growth*

In recent years, the NFPP has been integrated into the National Health Mission (NHM) framework, reflecting a shift towards holistic reproductive, maternal, newborn, child, and adolescent health (RMNCH+A) services. The program continues to adapt by promoting a wider range of contraceptive options, emphasizing informed choice and quality of care, and focusing on underserved populations to achieve sustainable population stabilization and improved health outcomes for all.

## 6. National Mental Health Program (NMHP)

◆ *Promote Rehabilitation*

The National Mental Health Program (NMHP) was launched in 1982 by the Government of India as a pioneering effort to address the growing burden of mental health disorders across the country. At a time when mental health was neglected mainly and stigmatized, the NMHP aimed to create awareness about mental health issues, improve access to treatment, and promote rehabilitation services for individuals suffering from mental illnesses. The program was motivated by the recognition that mental disorders significantly impact the overall well-being of individuals and communities. Yet, mental healthcare services remained limited, especially in rural and underserved areas.

◆ *Reducing Treatment Gap*

One of the key objectives of the NMHP is to integrate mental health services into the general healthcare system, ensuring that mental health care is accessible at primary, secondary, and tertiary levels. This integration allows for early identification, diagnosis, and treatment of mental health conditions, reducing the treatment gap that exists due to a lack of specialised facilities. The program also emphasizes capacity building by training general healthcare workers to provide basic mental health care, thus expanding the reach of services.



◆ *Community Programme*

The NMHP works actively to reduce the stigma associated with mental illnesses by promoting mental health awareness through community programs and educational campaigns. It also supports the development and strengthening of mental health infrastructure at the district and state levels, including mental hospitals and rehabilitation centres. Over time, the program has evolved to include initiatives such as the District Mental Health Program (DMHP), which extends services to the community level. Despite challenges such as inadequate funding and a shortage of mental health professionals, the NMHP remains a cornerstone of India's efforts to promote mental well-being and improve the quality of life for those affected by mental health disorders.

## 7. NVBDCP - National Vector Borne Disease Control Programme

◆ *Subtropical Regions*

The National Vector Borne Disease Control Programme (NVBDCP) was launched in 2003 by the Government of India to consolidate and strengthen efforts to control major vector-borne diseases such as malaria, dengue, chikungunya, and Japanese encephalitis. This program succeeded earlier fragmented initiatives and aimed to provide a comprehensive and coordinated approach toward the prevention, control, and management of these diseases, which contribute significantly to morbidity and mortality, especially in tropical and subtropical regions of the country.

◆ *Rapid Diagnostic Tests*

The NVBDCP's strategy includes a multi-pronged intervention package focused on reducing human-vector contact and transmission. Key components of this package are the distribution and promotion of insecticide-treated bed nets (ITNs), indoor residual spraying (IRS) with insecticides, and repellents to reduce vector exposure. The program also prioritizes active surveillance to monitor disease incidence and vector populations, prompt diagnosis through rapid diagnostic tests and laboratory services, and ensuring timely and effective treatment to affected individuals.

◆ *Education Campaigns*

High-risk areas, including rural, tribal, and urban pockets prone to outbreaks, receive special attention under the NVBDCP. The program collaborates with state governments and other stakeholders to implement localized control measures and outbreak response mechanisms. Capacity building, community engagement, and health education campaigns form an integral part of the program, aiming to raise awareness about prevention and encourage community participation.

◆ *Intervention package*

Since its inception, NVBDCP has contributed to significant reductions in disease burden, particularly in malaria and Japanese encephalitis endemic regions. It continues to evolve by adopting newer technologies and strategies, such as molecular diagnostics and integrated vector management, to adapt to changing epidemiological patterns and emerging challenges like insecticide resistance. The NVBDCP remains vital to India's public health system, demonstrating the government's commitment to controlling vector-borne diseases and improving population health.

### 8. Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (PMJAY)

◆ *Affordable healthcare services*

Launched in 2018, Ayushman Bharat is one of the largest health insurance schemes in the world. Under Pradhan Mantri Jan Arogya Yojana (PMJAY), the health cover for serious disease hospitalisation and treatment is free to the beneficiary families. The aim is to provide affordable healthcare services to all citizens, especially vulnerable and low-income families. PMJAY is also an integral component of the broader initiative Ayushman Bharat, whose other aspect is strengthening the primary healthcare services through Health and Wellness Centres (HWCs).

### 9. National Nutrition Mission (Poshan Abhiyaan)

◆ *Improving Child health*

The National Nutrition Mission (NNM), popularly known as Poshan Abhiyaan, was launched in 2018 by the Government of India with the goal of improving nutritional outcomes for children, adolescents, pregnant women, and lactating mothers. Recognizing the persistent challenge of malnutrition, especially among children under five years of age, the mission was designed to address issues such as stunting, under nutrition, anemia, and low birth weight, which have long-term effects on health, cognitive development, and productivity.

◆ *Supplementary Nutrition*

Poshan Abhiyaan is a flagship program that adopts a comprehensive and multi-sectoral approach to nutrition by coordinating efforts across various government departments such as health, women and child development, education, and sanitation. The program emphasizes real-time monitoring, use of technology, and data-driven decision-making to track progress and identify gaps in service delivery. Through this mission, vulnerable groups receive

direct nutrition interventions, including supplementary nutrition, micronutrient supplementation, and counseling on appropriate dietary practices.

◆ *Support vulnerable groups*

An important feature of the mission is its focus on community participation and behavior change communication to promote better feeding, hygiene, and health practices at the household and community levels. The program also strengthens the capacity of frontline workers such as Anganwadi and Accredited Social Health Activists (ASHAs) through training and supportive supervision. Since its inception, Poshan Abhiyaan has aimed to reduce stunting by 6% and undernutrition by 3% annually. It also supports nutrition surveillance and outreach programs to identify and assist malnourished children and women early. By integrating nutrition with health and sanitation efforts, the National Nutrition Mission represents a significant step toward ensuring a healthier and more nourished future for India's population, reflecting the government's commitment to tackling malnutrition through targeted and innovative strategies.

### 10. National Rural Drinking Water Programme (NRDWP)

◆ *Water delivery systems*

The National Rural Drinking Water Programme (NRDWP) was launched in 2009 by the Ministry of Drinking Water and Sanitation, Government of India, as a centrally sponsored scheme. Its objective was to provide every rural person with an adequate, safe, and sustainable drinking water supply, ensuring better health and hygiene outcomes for rural communities. This program shifted from infrastructure-focused water delivery systems to a more holistic, demand-driven, community-managed approach.

◆ *Rainwater harvesting*

The NRDWP replaced earlier water supply programs and introduced features like sustainability, participatory planning, decentralized implementation, and quality monitoring. It focused on building and maintaining infrastructure like hand pumps, bore wells, pipelines, and filtration plants, especially in areas with high contamination levels such as fluoride, arsenic, and salinity. A key emphasis of NRDWP was the promotion of rainwater harvesting, water resource sustainability, and groundwater recharge. Community participation became central, with Village Water and Sanitation Committees (VWSCs) leading in planning, implementing, and managing local water supply schemes.

The program also established frameworks for water quality testing laboratories and monitoring mechanisms at the district and state levels to reduce waterborne diseases.

◆ *Quality monitoring*

Despite its achievements, challenges such as slippages in coverage, poor operation and maintenance, and limited convergence with sanitation programs persisted. These gaps led to the evolution of the Jal Jeevan Mission (JJM) in 2019, which subsumed NRDWP and brought renewed focus on providing functional household tap connections (FHTCs) to every rural household by 2024. Thus, the NRDWP laid the foundation for long-term water security in rural India and highlighted the importance of clean drinking water as a fundamental right, contributing to public health, especially in marginalized and underserved areas.

### 4.2.2 Healthcare Delivery System in India

◆ *Resource Access*

India's healthcare delivery system is rather unwieldy, with public and private sector organizations providing health services to the populace. It caters to a large and diverse population with various socio-economic statuses, urban and rural divides, and resource access. Although India has made significant progress in enhancing access to healthcare and outcomes, particularly in addressing challenges, the system still confronts inadequate infrastructural resources, a shortage of health professionals, and inequitable access to quality services. An overview of the healthcare delivery system in India is provided in the section below.

The Healthcare Delivery system in India is organised into Sub-Centres, Primary Health Centres (PHCs), and Community Health Centres (CHCs). These institutions follow strict rules and responsibilities, but often suffer from inefficiencies such as a lack of autonomy, procedural delays, and the absence of accountability issues that Weber predicted in highly bureaucratic systems.

◆ *Quality of service*

According to the Rural Health Statistics (2022), India has around 1, 59,790 Sub-Centres, 30,713 PHCs, and 5,624 CHCs. However, 13% of PHCs operate without a doctor and 39% lack lab technicians, indicating a shortage of skilled personnel. Furthermore, the NSSO 75th Round (2019) shows that 42% of rural households must travel more than 5 kilometres to access a healthcare facility. Additionally, 23% of rural respondents reported unaffordable healthcare costs. These statistics reveal significant gaps in service delivery, especially in rural and



tribal regions, where people remain underserved despite the presence of infrastructure.

## 1. Public Healthcare System

In principle, the Indian government manages the public healthcare system at three levels: the centre, the states, and local self-government. The healthcare system strives to provide essential healthcare services to the general population, especially those who cannot afford private care. Some of the key features of the public healthcare system are

◆ *General population*

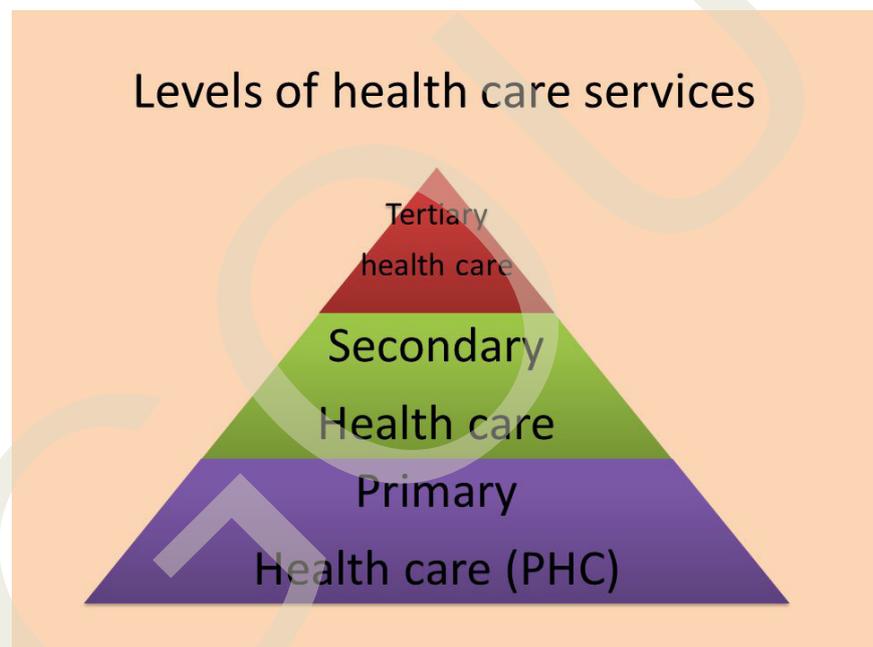


Figure 4.2.1: Levels of the Healthcare System

◆ *Grassroots level*

**a) Primary Health Care:** Primary health care at the grassroots level in the national health system was provided through a network of primary health centres and subcentres. These centres generally represent the first contact of the people seeking medical care. PHCs maintain essential services relating to maternal and child healthcare, immunization, treatment for common ailments, and preventive health services. Many PHCs are situated in rural and underserved areas to make health services accessible.

**b) Secondary Health Care:** The district hospitals and the CHCs provide secondary health care. These centres offer specialized services, such as surgery, obstetrics, and chronic illness management. CHCs at the block level also

◆ *Community health service*

act as referral centres for PHCs. The government runs many national health programs for major public health problems, such as tuberculosis, HIV/AIDS, maternal and child health, immunization, and vector-borne diseases. The programs have been designed to deliver services at the community's doorstep through primary and secondary healthcare networks.

◆ *Specialized Hospitals*

**c) Tertiary healthcare** involves treatments for complicated diseases and conditions through large-sized hospitals and specialized medical institutions. The services offered include treatment related to cancer, organ transplantation, cardiology, neurosurgery, and other similar systems. Some famous government institutions include the All India Institute of Medical Sciences (AIIMS), the Post Graduate Institute of Medical Education and Research (PGIMER), and state-run medical colleges.

## 2. Private Health Care System

◆ *Urban areas*

India's private health care system has grown by leaps and bounds in the last couple of decades and plays a vital role in health care provision, particularly in the urban areas. It comprises many providers- small clinics, nursing homes, and large corporate hospital chains. Some salient features of the private healthcare system are:

◆ *Specialized treatments*

**a) Private Hospitals and Clinics:** Private hospitals provide all types of healthcare services, ranging from specialized treatments to diagnostics, surgery, and emergency care. Such hospitals may have modern facilities, advanced equipment, and quicker access to care, but usually, all such facilities are available only to those who can afford the treatment. The concentration of private health providers in urban areas is higher.

◆ *Advanced technology*

**b) Specialized and Advanced Care:** Private providers shift to more specialized care and advanced treatments in cardiology, oncology, orthopaedics, and neurology. They usually appeal to patients looking for faster service, more comfort, and advanced technology not offered within the public system.



### 4.2.3 National Rural Health Mission (NRHM)

◆ *Improvement of Healthcare*

The National Rural Health Mission was launched in 2005 by the Government of India to give a facelift to the health delivery system in rural areas. It was meant to meet the deficiencies in rural healthcare with equitable, affordable, and quality health services, especially for vulnerable groups like women, children, and the underprivileged. NRHM works within the broader framework of the National Health Mission (NHM), which also covers the National Urban Health Mission (NUHM) initiated in 2013.

◆ *Promote rural healthcare*

Amartya Sen's Capability Approach is highly relevant to the goals of NRHM. The mission aims to expand people's capabilities by ensuring access to healthcare, particularly in rural and underserved areas. By enhancing maternal health services, immunization, and community-based healthcare through Accredited Social Health Activists (ASHAs), NRHM seeks to increase people's freedoms to lead healthy and dignified lives.

◆ *Health delivery system in rural areas*

As per the NHM Progress Report (2022), over 10 lakh ASHA workers have been deployed across India. They serve as a bridge between the healthcare system and rural communities. Due to their efforts, institutional deliveries in rural India rose from 60% in NFHS-3 (2005-06) to 88.6% in NFHS-5 (2019-21). Additionally, India's Maternal Mortality Ratio (MMR) has declined from 130 in 2014-16 to 97 in 2018-20. Despite these achievements, operational challenges persist, including delayed payments, inadequate training, and varying levels of community trust. These factors affect the consistency and reliability of NRHM services across different states.

◆ *Pluralism and decentralization*

### 4.2.4 The National Health Policy

The National Health Policy 2017 aims to provide universal access to high-quality healthcare services by increasing access and affordability, reducing the cost of healthcare delivery, and striving for equity. The policy envisages attaining the highest possible level of health and well-being for all ages through a preventive and primitive health care orientation in all developmental policies and universal access to good quality health care services without financial hardship. The guiding cardinal principles of the Policy will be Equity, Affordability, Universality, patient-centred care, Quality of care, Accountability, Inclusive partnership, Pluralism and Decentralisation.

The National Health Policy (2017) advocates for healthcare as a fundamental right. This aligns with the human rights approach, which treats health as a service and an entitlement. The policy calls for equity, universality, and financial protection, emphasizing that all citizens should have access to essential health services regardless of socio-economic status.

◆ *Universal access*

The theory critiques the influence of market forces on health systems. The increasing focus on Public-Private Partnerships (PPPs) and insurance-based models in NHP 2017 reveals a shift toward neoliberal healthcare provision. Such shifts may prioritize profit over equity, excluding vulnerable populations who cannot afford private healthcare or insurance premiums.

◆ *Marginalized populations*

The central Govt has taken several initiatives to supplement the efforts of the State in providing quality and affordable healthcare services to the people. The Government has undertaken many initiatives toward universal health coverage under the National Health Mission to strengthen the State Governments regarding access to and affordability of healthcare for people. The main building blocks are the two Sub-Missions of the National Rural Health Mission and National Urban Health Mission. The National Health Mission supports improvements in health infrastructure and adequate human resources to manage health facilities for improved availability and access to quality healthcare, particularly for the underserved and marginalized populations in rural areas

◆ *Central Government Scheme*

The government has undertaken four mission-mode projects, namely, PM-Ayushman Bharat Health Infrastructure Mission (PM-ABHIM), Ayushman Bharat Health & Wellness Centres (ABHWCs), Pradhan Mantri Jan Arogya Yojana (PMJAY), and National Digital Health Mission (NDHM). The PM-ABHIM was initiated with a mission to develop the capacities of primary, secondary, and tertiary care health systems, strengthen the existing national institutions, and build new institutions to detect and cure emerging and new diseases. The PM-ABHIM is a centrally sponsored scheme with some central sector components for implementing the Atmanirbhar Bharat Package for the health sector, which has an outlay of Rs 64,180 crore.

Strengthening sub-health and primary health centres will facilitate comprehensive primary health care under Ayushman Bharat Health & Wellness Centres. This will

◆ *Health care for every citizen*

provide preventive, promotive, rehabilitative, and curative care for an expanded range of services that will include reproductive and child care services, communicable diseases, non-communicable diseases, care for conditions requiring palliative care and elderly care, common mental disorders, neurological conditions such as epilepsy and dementia, management of substance use disorders including tobacco, alcohol, and drugs, oral health, ENT (Ear, Nose, and Throat.) care, and Basic emergency care. Ayushman Bharat Digital Mission aims to provide health care to every citizen. On 27th September 2021, it was announced that the backbone necessary to support the country's integrated digital health infrastructure will be developed. The mission will bridge the gap among the healthcare ecosystem's various stakeholders through digital highways.

#### 4.2.4.1 Evolution of Health Policy in India

◆ *Public health needs*

India's health policy has evolved significantly since independence, shifting from disease-specific programs to comprehensive approaches integrating public health, primary care, and equity in access. Each policy shift reflected changing public health needs, epidemiological transitions, and socio-economic contexts.

◆ *Health planning*

##### 1. Bhore Committee Report

Although predating independence, the Bhore Committee Report (1946) laid the groundwork for India's public health planning. It recommended a three-tier health system (primary, secondary, and tertiary) and the integration of preventive and curative services. It envisioned universal healthcare with no cost at the point of delivery.

◆ *Public-private partnerships*

##### 2. National Health Policy

Due to growing concerns over non-communicable diseases, health inequalities, and private sector expansion, the 2002 policy aimed to increase government health expenditure to 2% of GDP, promote public-private partnerships, and strengthen decentralized health services. It stressed access to essential drugs, HIV/AIDS prevention, and population stabilisation.

◆ *Community participation*

##### 3. Launch of NRHM and NHM

In 2005, the National Rural Health Mission (NRHM) was launched to revamp rural healthcare through community participation, deployment of ASHA workers, and

strengthening of sub-centres and PHCs. In 2013, the NRHM merged with the National Urban Health Mission (NUHM) to form the National Health Mission (NHM), expanding focus to urban slums and promoting reproductive, maternal, neonatal, child, and adolescent health (RMNCH+A).

#### 4. Ayushman Bharat

##### ◆ Family care

The launch of Ayushman Bharat in 2018 marked a paradigm shift by establishing Health and Wellness Centres (HWCs) for primary care and introducing the Pradhan Mantri Jan Arogya Yojana (PM-JAY) to provide ₹5 lakh insurance cover per family annually for secondary and tertiary care.

#### 5. Pradhan Mantri Samagra Swasthya Mission (PM-SSM)

##### ◆ Health schemes

Announced under the Union Budget 2021-22, the PM-SSM consolidated existing health schemes, including NHM, Ayushman Bharat, and disease control programs, aiming for a comprehensive, integrated, and accessible healthcare system focusing on public health infrastructure and surveillance.

## Summarised Overview

The health system in India is multilayered and responds to the very diverse needs of a large population. High on the list of challenges are communicable diseases like tuberculosis and malaria, along with maternal and child health problems relating to malnutrition and infant mortality. Of late, the burden of non-communicable diseases, especially cardiovascular diseases and diabetes, is increasing. National health programs, such as the Revised National Tuberculosis Control Programme (RNTCP), National AIDS Control Programme (NACP), and immunization campaigns, are designed to combat these issues. These programs are based on the principles of prevention, treatment, and creating awareness. However, they can succeed only if the strategies are properly implemented and evaluated to ensure they reach the most underserved communities. The health care system functions at three levels: primary, secondary, and tertiary care. Primary health care is disease prevention and dispensing essential medical services through sub-centres and primary health centres. District hospitals and community health centres render secondary care in terms of specialist care. At the same time, the tertiary level includes teaching hospitals, research institutes, advanced treatment, and super-speciality services. This three-tier health service is critical in gaining maximum access to all health services. Public-private partnerships may be particularly significant in bridging these resource gaps, bringing the best of both sectors to bear for better healthcare delivery, more so to the resource-constrained areas.



## Self-Assessment Questions

1. Describe the concept of the National Health Mission (NHM) and explain its primary objectives in strengthening India's healthcare system.
2. Discuss the scope of Emergency and Critical Care services within the Indian health sector and examine their role in life-saving interventions.
3. Explain how Community Health Workers (CHWs) contribute to healthcare delivery in India, particularly in underserved areas.
4. Examine the structure and functioning of the Health Care Delivery System in India and discuss why understanding it is crucial for effective health planning and management.
5. Explore the significance of the National Rural Health Mission (NRHM) in enhancing rural health infrastructure and reducing healthcare inequalities.
6. Distinguish between primary, secondary, and tertiary healthcare levels, and describe the defining characteristics of Tertiary Healthcare in India.
7. Discuss how the National Rural Health Mission (NRHM) and the National Health Policy shape India's healthcare landscape and examine their long-term implications on public health outcomes.

## Assignments

1. Explain the key focus areas of the National Health Policy (NHP) in India and how it aims to strengthen the country's healthcare system.
2. Describe the primary aim of the National Rural Health Mission (NRHM) and discuss how it addresses rural healthcare challenges.
3. Which level of healthcare delivery in India provides specialized services and complex treatments? Explain its role with suitable examples.
4. Identify the main features of Primary Health Care (PHC) and discuss its significance in the Indian healthcare delivery system.
5. Name the program launched under the NRHM to improve maternal and child health, and explain its major objectives and components.
6. Provide examples of tertiary-level healthcare facilities in India and discuss their role in delivering advanced medical care.



7. Discuss the key structural and functional features of India's healthcare delivery system and their relevance in ensuring healthcare accessibility.
8. Explain how the National Health Mission (NHM), particularly the NRHM component, represents a comprehensive approach to health system reform in India. Identify its key focus areas.

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## Suggested Reading

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## Space for Learner Engagement for Objective Questions

Learners are encouraged to develop objective questions based on the content in the paragraph as a sign of their comprehension of the content. The Learners may reflect on the recap bullets and relate their understanding with the narrative in order to frame objective questions from the given text. The University expects that 1 - 2 questions are developed for each paragraph. The space given below can be used for listing the questions.

SGOU



## Community Health Problems

### Learning Outcomes

On completion of the unit, the learner will be able to:

- ◆ explore the features and causes of Community Health Problems
- ◆ familiarize with the importance of Rural Health- Issues and Problems

### Background

Basic health concepts are necessary to study community health problems, especially in rural settings, effectively. This includes knowledge of general health, illness, well-being, and public and community health principles. A broad understanding of these concepts serves as the basis for examining health issues in rural settings, in which the healthcare delivery system and health problems could be very different from those experienced in urban centres. The other most relevant prerequisite is sensitization to socioeconomic factors and their direct relation with health outcomes. Socioeconomic conditions, including income levels, education, and means, greatly determine the health status of the rural population. Cultural practices, lifestyle choices, and local traditions also play a vital role in defining health behaviours and perceptions related to well-being. These socio-economic and cultural parameters are essential for addressing health problems in rural settings.

### Keywords

Rural Health Infrastructure, Health Indicator, Healthcare Workforce Availability, Cultural Competency



## Discussion

### ◆ *Availability of health workers*

A compelling study of community health problems, especially in rural settings, requires a broad comprehension of basic health concepts, including general health, illness, well-being, and public and community health principles. Challenges faced in rural healthcare systems are quite different from those of urban centres, mainly including infrastructure, fewer health centres, and a shortage of health professionals. Incomes, level of education, and local socio-cultural practices provide extreme modifiers of health status; thus, all levels with these broad elements become major building blocks shaping outcomes for each other: Health indicator allows the rates of mortality, morality rates help an excellent extent estimation of gaps or inequalities for NRHM programs nationally implemented targeting a disparity in reduction on rural. However, such programs are usually hampered by the availability of health workers and cultural factors that determine health behaviours.

### ◆ *Health status*

Community health challenges are various diseases affecting the health status of persons living in each area or population. Generally, such challenges tend to be shaped by social, economic, and environmental conditions that contribute to inequality in health outcomes. Those common ones include infectious diseases such as tuberculosis and malaria, opportunistic infections taking hold when proper sanitation does not exist, and general poor accessibility to health care.

### ◆ *The changing lifestyle*

The changing lifestyle, faulty diet, and lack of awareness make diabetes, hypertension, and cardiovascular conditions significant issues. Other major problems include nutritional disorders, maternal and child health, and psychic disturbances, among others, which are usually made worse by poverty, ignorance, and a lack of proper health services. Alcoholism and drug addiction further complicate community health with the creation of social and economic problems, such as environmental factors, such as pollution and unsafe water burdens, respiratory diseases and waterborne diseases. These need an integrated approach through public health policies, community involvement, education, and access to health services at all levels. This would bring in comprehensive strategies toward changing these factors of life for the betterment of health in the community.

### 4.3.1 Community Health Problems

- ◆ *Community Participation*

Community health problems encompass a wide range of issues that affect the well-being of populations within a specific geographic area. These problems often arise due to social, economic, environmental, and behavioural factors. Common community health concerns include infectious diseases, chronic illnesses such as diabetes and hypertension, malnutrition, mental health disorders, and substance abuse. Poor sanitation, lack of clean drinking water, and inadequate healthcare services exacerbate these challenges, particularly in underserved and rural areas. Addressing these problems requires a comprehensive approach that involves healthcare providers, policymakers, and community participation.

- ◆ *Specific area*

According to the NFHS-5 (2019–21), India grapples with serious community health challenges. A significant proportion of children under the age of five suffer from chronic undernutrition, with 36% being stunted and 32% underweight. The burden of anaemia remains alarmingly high, affecting 57% of women and 67% of children under five, which reflects deep-rooted nutritional deficiencies. Despite the efforts of the Swachh Bharat Mission, around 19% of rural households still lack access to adequate sanitation facilities, exacerbating health vulnerabilities. Furthermore, communicable diseases such as tuberculosis (TB), dengue, and diarrhoea persist, particularly in densely populated urban slums and remote tribal areas where healthcare infrastructure is often inadequate. Emerging health threats like mental health disorders and environmental pollution are gaining recognition but continue to be insufficiently addressed in public health policies and interventions, leaving critical gaps in the comprehensive management of community health.

- ◆ *Environmental factors*

Environmental factors play a significant role in shaping community health. Pollution, poor waste management, and exposure to hazardous chemicals contribute to respiratory diseases, skin conditions, and other health complications. Climate change has also emerged as a pressing concern, spreading vector-borne diseases, food insecurity, and displacement. Furthermore, social determinants like poverty, unemployment, and lack of education impact health outcomes by limiting access to nutritious food, healthcare services, and health literacy. These interconnected factors highlight the need for policies addressing health and its underlying social determinants.

- ◆ *multi-faceted approach*

Promoting community health requires a multi-faceted approach that includes preventive measures, education, and healthcare interventions. Public health initiatives such as vaccination programs, awareness campaigns on hygiene and nutrition, and regular health check-ups can help in the early detection and management of diseases. Community engagement is crucial in identifying health needs and developing culturally appropriate solutions. Additionally, collaboration between government agencies, non-governmental organizations, and local communities can ensure the effective implementation of health programs. By investing in preventive healthcare and improving socio-economic conditions, communities can work towards achieving better health outcomes and enhanced quality of life.

#### 4.3.1.1 Community

- ◆ *Geographical space*

A community is a social unit of individuals sharing common interests, values, norms, or geographical space. A basis for social contacts, a feeling of belonging, mutual assistance, and a common identity make up a community. Communities are described by the fact that people can share their culture, religion, profession, or common goals; therefore, communities significantly influence people's social experiences and well-being. Whether formed organically through geographical proximity or intentionally through shared interests, communities provide emotional and practical support, contributing to social cohesion and resilience.

- ◆ *Environmental influence*

Communities are dynamic and evolve based on social, economic, and environmental influences. In rural areas, communities are often characterized by close-knit relationships and a strong dependence on local resources. In contrast, urban communities tend to be more diverse and interconnected through technology and modern infrastructure. Advances in digital technology have rapidly evolved the concept of community through virtual connections, allowing people to connect based on shared interests or professional affiliations, transcending geographical boundaries. However, even with all this change, at its core, a community revolves around mutual support, cooperation, and collective problem-solving.

The better the community is, the healthier its members become. Social inclusion, economic opportunities, healthcare, education, and employment, among other things, help promote the overall welfare of members of such a community. Effective community development requires

◆ *Social inclusion*

active participation by its members, government support, and collaboration with non-governmental organizations in tackling local challenges that improve the quality of life. By fostering a sense of responsibility and engagement among its members, communities can work towards sustainable development, social equity, and resilience against poverty, health crises, and environmental changes.

◆ *Promoting healthy lifestyles*

### 4.3.1.2 Community health

Community health is the collective well-being of individuals within a specific geographic area or social group. It includes preventing disease, promoting healthy lifestyles, and ensuring access to healthcare services for all community members. Various factors, including social determinants such as income, education, environment, and access to healthcare facilities, influence community health. A well-functioning community health system focuses on improving health outcomes through public health initiatives, awareness programs, and preventive care strategies to address prevalent health issues within the community.

◆ *Quality of life*

The primary goal of community health is to enhance the quality of life by reducing health disparities and ensuring that everyone has equal opportunities to achieve good health. This will involve a multidisciplinary approach, including healthcare professionals, policymakers, community leaders, and individuals. Community health challenges common today include the spread of infectious diseases, chronic illnesses like diabetes and heart disease, substance abuse, mental health disorders, and poor access to sanitation and clean sources of drinking water. These would require comprehensive actions in designing health education programs, vaccination campaigns, and assurance of affordable healthcare services that involve various populations' basic needs.

◆ *Public health campaigns*

Traditionally, many community health initiatives focus on prevention, including, but not limited to, health promotion campaigns, physical fitness promotions, and early disease screenings. Public health campaigns on vital issues such as nutrition, hygiene, and vaccination may significantly promote disease prevention and increase general health. Moreover, proper coordination among the government, non-government sectors, and other local stakeholders will ensure adequate resource allocation for all community members' access to health facilities. By strengthening community health systems, societies can work towards achieving sustainable

health development and fostering healthier, more resilient communities.

### 4.3.1.3 Community Health Problems

◆ *Range of issues*

Community health problems are a broad range of issues that have to do with the well-being of people within a specific geographical area or social group. They emanate from various social, economic, environmental, and behavioural factors. Addressing them is essential for the maintenance of a healthy and productive society. Community health problems can be grouped into categories based on their nature and causes, each requiring targeted interventions and collaborative efforts from governments, healthcare providers, and the community.

◆ *Lack of nutritional deficiency*

There are various community health problems, each with its own challenges. Communicable diseases, such as tuberculosis, malaria, and COVID-19, are spread through person-to-person contact, contaminated water, and vectors like mosquitoes. They are particularly prevalent in areas with poor sanitation and inadequate healthcare access. Non-communicable diseases (NCDs), on the other hand, include chronic conditions such as diabetes, hypertension, and heart disease. These diseases often result from lifestyle factors such as unhealthy diets, physical inactivity, and environmental pollution. Another serious health issue that arises from the lack of necessary nutrients needed to avoid suffering from conditions such as anaemia, obesity, and stunted growth, especially in children and other low-income households, is nutritional deficiency.

◆ *Over pollution*

Other environmental health concerns expose many communities to possible risks. Examples include pollution, contaminated water for drinking and poor waste management, which results in respiratory ailments, skin diseases, and several other life-threatening health conditions. Climate change further increases these problems by increasing the incidence of vector-borne diseases and food insecurity. Another area of concern is mental health disorders, such as depression, anxiety, and substance abuse, which have significant impacts on quality of life and social functioning. Social isolation, unemployment, and financial stress all contribute to increased mental health problems, which often go untreated because of stigma and lack of resources. Occupational health hazards also pose risks to community members, particularly those in sectors such as sanitation, construction, and agriculture, where exposure to harmful

chemicals and unsafe working conditions can lead to chronic illnesses and injuries.

◆ *Large population*

The features of community health problems highlight their complexity and the need for comprehensive approaches to address them. One key feature is their widespread impact, as these health issues affect large populations and significantly burden healthcare systems and economic productivity. Social and economic determinants play a crucial role in shaping health outcomes, with poverty, education, employment, and living conditions influencing access to healthcare services and healthy lifestyle choices. Many community health problems are preventable, emphasising the importance of proactive measures such as health education, vaccination programs, and improved sanitation.

◆ *Chronic diseases*

Another important feature of community health problems is their interconnectedness. Health issues are often linked, meaning that one problem, such as malnutrition, can contribute to another, like weakened immunity and increased susceptibility to infections. Effective management of these problems requires active community participation, as local engagement is essential in understanding specific health needs and developing culturally appropriate solutions. In addition, resolving these issues requires long-term efforts because neglecting these issues may develop into chronic diseases, reduce life expectancy, and increase health care costs. The availability of resources in health care, including human resources, infrastructure, and finance, determines how these problems are managed.

◆ *Balanced Health*

### 4.3.2 Rural Health Problems

Rural health problems and issues are significant in most developing regions; therefore, a country like India needs a balanced health infrastructure and services. Poor health conditions result from a lack of proper health facilities in rural areas. This condition has worsened because of improper transportation systems and long distances to reach health centres, for which timely intervention has always been complex.

The infectious diseases prevalent in rural health include malaria, tuberculosis, and waterborne ailments, often driven by poor sanitation and a lack of clean drinking water. Malnutrition remains a problem, particularly amongst children and women, since there is widespread poverty and a limited number of diverse diets, primarily due to a

◆ *Poor Sanitation*

lack of nutrition education. Moreover, non-communicable diseases such as hypertension, diabetes, and cardiovascular diseases are increasingly affected by lifestyle changes, a lack of awareness, and inadequate facilities for screening and subsequent treatment.

◆ *Lack of awareness*

Rural India is home to approximately 65% of the country's population, yet it remains critically underserved regarding healthcare infrastructure and services. Alarming, only about 20% of doctors practice in rural areas, highlighting a severe urban-rural disparity in healthcare access (Ministry of Health and Family Welfare, 2023). Each Primary Health Centre (PHC) in rural regions caters to nearly 30,000 people, three times the World Health Organization's recommended ratio of 1:10,000. According to the Rural Health Statistics 2022, Community Health Centres (CHCs) face a staggering 83% shortfall in specialist doctors, severely limiting the capacity to handle complex health issues in rural areas. As a result, maternal and infant mortality rates remain significantly higher in these regions compared to their urban counterparts. Also, persistent problems such as open defecation, unsafe drinking water, and inadequate waste management systems continue to contribute to the prevalence of communicable diseases like diarrhoea, jaundice, and respiratory infections. These systemic gaps illustrate the urgent need for targeted healthcare interventions in rural India.

◆ *Maternal Problem*

Maternal and child health problems also constitute an added burden in rural settings. High maternal mortality rates arise due to a lack of appropriate prenatal and postnatal care, while poor immunization coverage and malnutrition are contributing factors to the high rate of infant mortality. Mental health problems, although less acknowledged, are made worse by social stigma, lack of awareness, and unavailability of mental health professionals.

◆ *The insufficient health workforce*

The insufficient health workforce in rural areas exacerbates this issue with inadequate doctors, nurses, and auxiliary health workers. Traditional beliefs and cultural practices can also create obstacles to the acceptability of modern medical interventions. Rural health issues require multifaceted strategies addressing better health infrastructures, improving transportation networks, increasing health personnel in rural areas, and creating health awareness through education and community-based programs.

## 1. Limited Access to Healthcare Facilities

### ◆ *Financial incapability*

One of the significant health challenges characterizing the rural setup is limited access to healthcare facilities. Most rural areas in developing countries, such as India, are reported to have underdeveloped healthcare infrastructures. Most lack primary health centres, district hospitals, and other medical facilities needed to provide quality care. This means that people have to cover long distances to get to a hospital or clinic, which may be unreachable due to impassable roads, lack of means of transport, or financial incapability.

### ◆ *Shortage of qualified doctors*

Another very critical issue at hand is the shortage of healthcare providers. Most rural areas experience a shortage of qualified doctors, nurses, and other personnel in the field of medicine, which contributes to long waiting times and incomplete service. When health facilities exist, underfunding, poor equipment and understaffing undermine their ability to provide emergency services, maternal health care, and chronic disease care. For this reason, access to health is poor, influencing preventive services such as vaccinations, screenings, and health education needed to keep community health up to standard.

## 2. Shortage of Medical Professionals

### ◆ *Less opportunities*

The shortage of medical professionals in rural areas is a major contributor to the poor health outcomes in these regions. Rural communities often face significant disparities in healthcare access due to a lack of qualified doctors, nurses, and other healthcare workers. This shortage is driven by various factors, including migrating healthcare professionals to urban centres for better opportunities, limited incentives for working in rural areas, and a lack of infrastructure to support healthcare careers. As a result, rural healthcare facilities are often understaffed, leading to overworked professionals and insufficient care for the population.

This shortage limits access to routine healthcare services and exacerbates challenges during emergencies, maternal care, and chronic disease management. With fewer healthcare providers available, patients in rural areas often experience longer wait times, limited consultations, and delayed treatments. Furthermore, the absence of specialized healthcare professionals in remote regions forces residents to travel long distances to urban centres for specialized care,

◆ *Limited access*

which can be costly and time-consuming. Addressing this shortage requires targeted policies, such as offering financial incentives, improving working conditions, and increasing the number of medical training programs in rural regions. There is also a need for better infrastructure and telemedicine initiatives to bridge the gap in healthcare delivery.

◆ *Cleaning Water*

The high prevalence of infectious diseases in rural areas is a significant health concern driven by multiple factors such as poor sanitation, lack of clean drinking water, overcrowded living conditions, and limited access to healthcare. In rural regions, diseases like malaria, tuberculosis, diarrhoea, and respiratory infections are more common due to inadequate health infrastructure and hygiene practices. Stagnant water sources, poor waste management, and lack of public health education create an environment where infectious agents can quickly spread, leading to frequent outbreaks.

◆ *Expanding healthcare infrastructure*

Infectious diseases often affect vulnerable populations, including children, the elderly and pregnant women, who are more susceptible to severe complications or death. Malaria, for instance, thrives in areas with poor mosquito control measures, while waterborne diseases like cholera and dysentery are common in communities with inadequate water treatment facilities. Additionally, the limited availability of healthcare services in these areas makes it challenging to provide timely diagnosis, treatment, and preventive care, further exacerbating the problem. Addressing the high prevalence of infectious diseases in rural areas requires improving sanitation and hygiene, increasing access to clean water, promoting vaccination, and expanding healthcare infrastructure. Public health initiatives focusing on education, vector control, and strengthening healthcare systems are also crucial for reducing the burden of infectious diseases in these communities.

◆ *Postnatal support*

Maternal and child health challenges are a significant concern in rural areas, where access to healthcare is often limited and socio-economic conditions are typically poor. High maternal mortality rates are a significant issue, with many women in rural regions not receiving adequate prenatal care, skilled birth attendance, or postnatal support. These

### 3. High Prevalence of Infectious Diseases

### 4. Maternal and Child Health Challenges

factors increase the risks of complications during childbirth, such as haemorrhage, infection, or eclampsia, which can be fatal without proper medical intervention. Limited access to healthcare facilities, particularly emergency obstetric care, further exacerbates the situation.

Indicator	India (2020–22)	Kerala (2020–22)
Maternal Mortality Ratio (MMR) (per 100,000 live births)	97	19
Infant Mortality Rate (IMR) (per 1,000 live births)	28	6

## 5. MMR and IMR in India and Kerala

### Reasons for Low MMR and IMR in Kerala (Compared to National Average)

#### a. High Literacy Rate (especially Female Literacy)

Kerala's female literacy rate is over 92%, compared to the national average of around 70%. Educated mothers are more likely to access antenatal care, institutional delivery, and postnatal services.

#### b. Strong Public Health Infrastructure

Kerala has a well-functioning network of Primary Health Centres (PHCs), Community Health Centres (CHCs), and government hospitals. The Aardram Mission and Family Health Centres have further improved service delivery.

#### c. Universal Access to Institutional Delivery

Over 99% of deliveries in Kerala are institutional, significantly reducing complications during childbirth. Trained birth attendants and emergency obstetric care contribute to lower maternal deaths.

#### d. Robust Immunization and Child Care Services

Kerala achieves nearly 100% immunization coverage,



reducing neonatal infections and preventable deaths. Regular growth monitoring and early treatment of infections in infants are routine.

**e. Effective Public Health Campaigns and Community Participation**

◆ *Reducing maternal and child mortality*

High maternal and child health awareness through grassroots health workers (ASHA, Anganwadi) and local self-government interventions.

**f. Socio-Economic Development**

Kerala has better nutrition, housing, water supply, and sanitation facilities, key determinants of maternal and child health outcomes.

**6. Malnutrition**

◆ *Food insecurity*

It is a significant health issue in rural areas, where food insecurity, poor dietary habits, and limited access to nutritious food contribute to widespread undernutrition. In these regions, malnutrition manifests as stunting, wasting, and micronutrient deficiencies. Stunting, or low height for age, affects children who do not receive enough nutrients during critical periods of growth, while wasting, or low weight for height, results from inadequate caloric intake and illness. Micronutrient deficiencies, such as iron, vitamin A, and iodine, are also prevalent and can lead to severe health issues like anaemia, vision problems, and developmental delays



Figure 4.3.1 Malnutrition

The root causes of malnutrition in rural areas are complex and include poverty, limited access to diverse and affordable foods, lack of nutrition education, and inadequate healthcare. Families in rural areas often rely on staple foods low in essential nutrients, with many fruits, vegetables, and animal-

◆ *Multi-faceted approach*

based proteins being out of reach. Seasonal fluctuations in food availability, as well as poor storage facilities, exacerbate the problem. The consequences of malnutrition are far-reaching. For children, chronic malnutrition can lead to stunted physical and cognitive development, while adults may experience reduced productivity, higher susceptibility to illness, and increased risk of maternal complications. In rural communities, where healthcare infrastructure is limited, malnutrition often goes untreated, leading to long-term health problems. Addressing malnutrition requires a multi-faceted approach, including improving food security, increasing access to nutrient-rich foods, educating communities on proper nutrition, and strengthening healthcare services to treat malnourished individuals and prevent further complications.

◆ *Health awareness*

Malnutrition in India remains a significant public health challenge, particularly among children under five, pregnant women, and adolescents. According to the National Family Health Survey-5 (NFHS-5, 2019-21), 35.5% of children under five are stunted (low height-for-age), 19.3% are wasted (low weight-for-height), and 32.1% are underweight (low weight-for-age). Despite improvements over the past decades, the decline has been slow. The Global Hunger Index 2023 ranked India 111th out of 125 countries, indicating severe hunger and malnutrition. Among women aged 15-49 years, 57% are anaemic, and among children aged 6-59 months, the figure rises to 67%, highlighting a crisis in nutritional intake and health awareness. While schemes like Poshan Abhiyaan, Mid-Day Meal Scheme, and Integrated Child Development Services (ICDS) have progressed, malnutrition continues to be deeply entrenched in certain socio-economic pockets.

◆ *Food insecurity*

The persistence of malnutrition in India can be attributed to several interrelated factors. Poverty remains a significant barrier, limiting access to nutritious food and healthcare. Despite economic growth, many families cannot afford balanced diets, particularly in rural and tribal areas. Lack of maternal education is critical, directly affecting infant feeding practices, hygiene, and health-seeking behaviour. Poor sanitation and unsafe drinking water contribute to repeated infections like diarrhoea, impairing children's nutrient absorption. Additionally, gender inequality leads to preferential feeding of male children and poor nutrition among girls and women. Public distribution systems often emphasize calorie-dense but nutrient-poor foods, while fragmented implementation of welfare programs weakens

impact. Seasonal food insecurity further aggravates the issue, particularly in agrarian and drought-prone regions. Combating malnutrition thus requires an integrated approach involving food security, healthcare access, education, sanitation, and targeted nutritional interventions, especially in underserved populations.

## 7. Non-communicable diseases (NCDs)

The rise of non-communicable diseases (NCDs) in rural areas is becoming an increasingly significant health issue. NCDs, which include diseases such as heart disease, stroke, diabetes, hypertension, and cancer, were once considered predominantly urban health concerns. However, lifestyle changes, shifting dietary patterns, and reduced physical activity have also made these diseases more prevalent in rural regions. With growing affluence, rural populations are adopting unhealthy diets high in processed foods, sugars, and fats, while traditional, healthier diets are being pushed aside. At the same time, rural areas often lack adequate healthcare facilities for early detection, screening, and management of NCDs, further complicating the problem.

### ◆ *Healthcare management*

Factors like limited access to preventive health services, a lack of awareness about the risks of these diseases, and inadequate healthcare infrastructure exacerbate the rising incidence of NCDs. Rural communities may not have easy access to healthcare professionals trained to manage chronic conditions, and healthcare facilities may be ill-equipped to provide the necessary care. Additionally, the limited availability of diagnostic tools, as well as the high cost of medications for conditions like diabetes and hypertension, pose a barrier to effective treatment.

### ◆ *Availability of diagnostic tool*

Another contributing factor is the increasing prevalence of risk factors such as tobacco use, alcohol consumption, and physical inactivity. While these behaviours are common in rural and urban populations, their impact is often more pronounced in rural areas due to limited access to wellness programs and lifestyle interventions. Strategies such as improving health literacy, strengthening primary healthcare infrastructure, and promoting healthy lifestyle choices are crucial to addressing the rising burden of NCDs. Early detection programs, regular screenings, and affordable treatment options are key to managing the growing challenge of NCDs in rural communities.

### ◆ *Lifestyle interventions*

## 8. Mental Health Stigma

### ◆ *Cultural beliefs*

Mental health stigma and negligence in rural settings are significant challenges, as cultural beliefs and a lack of awareness of these issues have led to isolation and rejection by their people. Most of the rural communities still believe that mental disorders are taboo or a sort of weakness; therefore, instead of seeking help, they hide them. This subsequently leads to social exclusion, guilt, and a reluctance to use available services, in turn perpetuating mental health problems.

### ◆ *Psychiatric care*

A shortage of mental health professionals in rural areas further compounds the issue of mental health. Since there are few or no psychologists, psychiatrists, and counsellors in most rural regions, proper access to care for the residents living therein is quite problematic. Services are frequently underfunded or understaffed, even when they exist. A general lack of awareness of mental health services is also common. Very often, traditional healing practices and beliefs interfere with accepting modern psychiatric care and may lead individuals to seek community-based or spiritual remedies rather than seeking professional help.

### ◆ *Physical complications*

As such, rural dwellers often suffer in silence; hence, if left untreated, the mental health problem further leads to physical complications, substance abuse, or suicide. It is necessary to reduce mental health stigma and negligence in rural settings with cultural sensitivity, public education campaigns to lower stigma, as well as integration into primary health systems. Others involve the scale-up of telemedicine and mobile health services and training of local health providers to improve the identification and management of mental health problems as a means of increasing access to mental health care with reduced stigma associated with its treatment.

## 9. Inadequate Health Infrastructure

### ◆ *Proper service*

One of the significant obstacles to effective health delivery in rural areas is the inadequacy of health infrastructure. Many rural districts lack basic health facilities like well-equipped primary health centres, district hospitals, and specialized medical services. The few available facilities often remain underfunded and poorly maintained, thus limiting their capability to deliver even essential healthcare services. For



example, specific health centres located in rural areas may lack access to electricity, clean water, or medical equipment. Finally, the scarcity of physicians, nurses, and technicians skilled in healthcare worsens the situation by prolonging waiting lists, keeping hospitals considerably understaffed, and withholding proper service from patients.

India's health infrastructure has improved with initiatives like the National Health Mission, yet it faces significant challenges. As per Rural Health Statistics 2021-22, India has over 1.5 lakh Sub-Centres, 30,000+ Primary Health Centres (PHCs), and around 6,000 Community Health Centres (CHCs), but a large number of these lack adequate infrastructure and staff. Over 70% of CHCs are without specialist doctors. Public health spending remains low at about 2.1% of GDP, and out-of-pocket expenses account for nearly 48.2% of health costs. In contrast, Kerala showcases robust public health models with almost 100% functional PHCs, a doctor-patient ratio of about 1:600, and higher per capita health expenditure (₹2,000 compared to the national average of ₹1,200). Kerala also leads in health indicators, with an Infant Mortality Rate (IMR) of just 6 per 1,000 live births versus the national average of 28. This reflects the state's emphasis on primary care, literacy, and decentralized governance.

◆ *Health Indicates*

Lack of adequate health infrastructure also extends to emergency care, wherein rural area patients often have to travel long distances to reach the nearest hospital, resulting in delayed treatment and heightened mortality rates. Besides, vaccination programs, maternal and child health services, and screening of non-communicable diseases are either not well-practised or not practised at all in many rural areas. This increases the vulnerability of rural populations to diseases, poor health outcomes, and lower life expectancy compared to urban areas.

◆ *Emergency care*

Each of these infrastructural challenges demands serious investments in health facilities, roads, and other means of transport and incentives that will attract medical professionals to rural areas. In addition, the introduction of telemedicine and mobile health can bridge some gaps by providing remote consultations and follow-up care. Full-scale strengthening of healthcare infrastructure guarantees access to quality care and reduces health disparities between rural and urban populations.

◆ *Quality care*

## Summarised Overview

Rural health is a unique set of challenges often quite different from those faced in urban areas. Rural populations face inadequate access to health care, insufficient health infrastructure, and a lack of trained professionals. Rural areas usually have fewer health facilities, such as primary health centres and hospitals, making it hard for people to access essential services, especially in remote areas. This lack of access mostly leads to delayed diagnosis, inadequate treatment, and increased morbidity and mortality rates. Furthermore, the rural health workforce is usually understaffed, with most health professionals facing challenges in terms of isolation, lower salaries, and limited resources, which increase the barriers to providing quality care.

The health problems faced by rural populations are mainly related to socio-economic factors. High levels of poverty, lower educational attainment, and limited employment opportunities all often come together with poor health outcomes. Inadequate housing, lack of sanitation, and limitations in health education contribute to malnutrition, maternal and child health problems, and infectious diseases such as tuberculosis and malaria in rural areas. Cultural factors also determine health behaviours and perceptions, where rural populations may hold onto traditional health practices that may conflict with modern healthcare interventions. The multi-faceted approach to addressing these health issues should be grounded in improving infrastructures, increasing access to health care services, and enhancing the health workforce for rural areas while considering the socio-cultural context that shapes health behaviours and practices in these communities.

## Self-Assessment Questions

1. Identify a significant health issue commonly faced by rural populations in India and discuss the factors contributing to its prevalence.
2. Explain the primary challenges in developing and maintaining healthcare infrastructure in rural areas. Provide relevant examples.
3. Discuss any one major government initiative aimed at improving rural healthcare and evaluate its impact on rural health outcomes.
4. What are the common causes of waterborne diseases in rural areas? Explain how these affect public health and possible preventive measures.
5. Examine the key factors that contribute to poor health outcomes in rural communities and suggest strategies to address them.



6. Describe one of the most common maternal health issues affecting women in rural areas and explain the challenges in addressing it.
7. What is an example of an indigenous healthcare practice in rural India? Discuss its cultural relevance and potential role in community health.

## Assignments

1. Explore the factors influencing health outcomes in rural communities, focusing on socio-economic, cultural, and environmental aspects.
2. Examine the role of healthcare infrastructure in rural areas.
3. Critically examine rural health centres' significant challenges in delivering adequate healthcare services in India. Discuss potential strategies and policy interventions that can be implemented to overcome these challenges and strengthen rural health infrastructure.
4. Discuss the health problems most prevalent in rural settings, emphasising malnutrition, maternal health, and infectious diseases.
5. Discuss the key strategies that can be implemented to strengthen the rural healthcare workforce in India. In your answer, examine current challenges, proposed policy measures, capacity-building initiatives, and the role of community participation in improving rural health services.
6. Analyze the effectiveness of government health initiatives like NRHM and health campaigns in improving the health of rural populations.
7. Investigate the impact of cultural beliefs and practices on healthcare behaviours in rural communities.
8. How do qualitative and quantitative methods contribute to gathering data on community health problems, and what ethical considerations are involved?

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## Globalization and Health Sector

### Learning Outcomes

On completion of the unit, the learner will be able to:

- ◆ familiarise the relationship between Globalisation and the Health Sector
- ◆ explore the importance of Privatisation
- ◆ analyse the Consumer Protection Act

### Background

Globalization has deeply impacted health, transforming the nature of healthcare delivery, access, and cost in much of the world. One significant area affected by globalization is the privatisation of healthcare, where more and more services are being provided by private rather than public institutions. This may bring better efficiency and quality to the few who can afford private care but will also exacerbate inequalities, particularly in poor and rural areas. This only tends to increase the chasm in health services between the better-off sections and those dependent on public health services that, in turn, often suffer from a lack of funding and resources. Another important factor in global health is patents and their implications for poor people. Pharmaceutical companies tend to have patents over important drugs, preventing access to affordable treatments in poor countries. Then again, patented drugs are generally priced so exorbitantly high, making them often unaffordable even for the most impoverished sectors, thus exacerbating health inequity.

This is why debates on this balance of the need for intellectual property protection and public access to health continue to influence contemporary policies, especially in developing nations. Health care is a human right, albeit generally, health services are a source of tribulations for many segments of society, especially in most countries. This has led to the development health insurance systems that aim to provide broader coverage. However, the affordability and effectiveness of these systems are always in question, especially for the marginalized communities who may be excluded from comprehensive insurance schemes. Besides, the



Consumer Protection Act also plays a crucial role in protecting rights to safe and effective health care services. The act offers legal recourse to patients who suffer from medical negligence, malpractice, or inadequate services, helping keep the health providers accountable. Globalisation has presented both opportunities and challenges in the health sector. On the one hand, it has facilitated the sharing and exchange of medical knowledge and technology; on the other hand, it has exacerbated inequalities and raised complex ethical and legal questions concerning access to health care and the protection of consumers in the health market.

## Keywords

Globalization, Privatisation, Patents, Health Insurance, Health Inequities

## Discussion

### ◆ *Privatisation*

Globalization has brought a sea change in the health sector, presenting opportunities and challenges. Privatisation of health services has increased as private entities take over the delivery of health services that public institutions once managed. This shift has brought better quality and efficiency for those who can afford private healthcare but has also increased disparities in access to healthcare, especially among economically weak populations. The public healthcare system usually lags due to the problem of underfunding, which leads to overcrowding, increased waiting periods, and finally, fewer resources, increasing the health quality gap between rich and poor. The second major issue related to globalization and health care is patents, mainly on life-saving drugs. Pharmaceutical companies often hold patents on essential drugs, which can drive up costs to unaffordable levels for people in many low-income countries. Otherwise, those people will suffer from diseases that could be treated, and the pharmaceutical companies will continue reaping profits because of the high prices of drugs with active patents. It has brought about a global debate over balancing intellectual property rights with public health needs, where many advocates are urging reforms to allow more access to affordable medicines.

The right to health is one of the cornerstones of global health policies, yet considerable barriers remain in ensuring



◆ *Universal access*

universal access to healthcare. While health insurance schemes are supposed to offer financial protection, issues of affordability and accessibility remain, especially for the marginalized who can hardly afford comprehensive coverage. In some countries, establishing public health insurance systems has been a step toward universal health coverage. However, cost, exclusion, and the scope of services persist. On the other hand, the consumer protection act has a crucial role in ensuring that healthcare services meet specific standards and that patients are protected from malpractice, negligence, and exploitation. It gives legal recourse to individuals harmed by medical errors or inadequate healthcare services, thus holding healthcare providers accountable and fostering patient safety.

◆ *Resource-poor settings*

Globalization has been affecting healthcare systems throughout the world both positively and negatively. On a positive note, globalization has opened ways to access the latest medical knowledge, technology, and available treatments worldwide. In many ways, especially with modern communication and transportation, healthcare professionals, even in remote areas, can engage with newly developed technologies like telemedicine and discoveries in the field of medicine. For example, genomics, pharmaceuticals, and diagnostic tools can readily be distributed to developing countries, increasing the level of care. However, there are also considerable drawbacks created by globalization. One of the most apparent downsides is the ease with which the spread of diseases across the globe is facilitated by increased travel. This may be illustrated by the COVID-19 pandemic, which demonstrated how a virus could take hold of a wired world and test healthcare systems to such a degree, especially in resource-poor settings.

◆ *Commercialisation*

The increase in non-communicable diseases like diabetes and heart disease has become a worldwide health burden. This can also heighten health inequity, in which rich countries and individuals benefit more from positive health changes going on in the world than poor regions of the world. For example, while high-income countries can implement or afford new treatments and technologies, low-income countries cannot attain basic health care. The effect is a disparity in health outcomes across regions. Furthermore, globalization also brought about the commercialisation of healthcare into private health entities and pharmaceutical companies that often dominate the market rather than genuinely emphasising concern for patients. This raises ethical concerns about the

accessibility and affordability of healthcare for marginalised populations.

#### 4.4.1 Globalisation and the Health Sector

◆ *Medical Service*

Globalisation has profoundly impacted the health sector, influencing healthcare systems, policies, and the delivery of medical services worldwide. It has facilitated the exchange of medical knowledge, technologies, and healthcare professionals across borders, leading to significant advancements in healthcare practices and improved health outcomes. Through increased connectivity and international collaboration, globalization has helped develop innovative treatments, faster responses to health crises, and the spread of best practices in healthcare management. On the other hand, globalization presents challenges such as the spread of infectious diseases, health inequities, and the commercialization of healthcare services.

◆ *Innovative Treatments*

Globalisation has significantly transformed India's health sector. According to the Economic Survey (2022-23), foreign direct investment (FDI) in India's health and pharmaceutical sectors rose by 400% over the past decade, indicating increased market penetration by global firms. While this has improved access to advanced medical technologies, it has also escalated treatment costs. The WHO Global Health Observatory reports that out-of-pocket expenditure accounts for over 50% of total health spending in India, disproportionately burdening the poor. Additionally, the influx of Western medical models has led to the neglect of traditional Indian systems such as AYUSH, creating a divide between urban high-tech care and rural primary healthcare services.



Figure 4.4.1 Globalisation and Healthcare

◆ *Global health challenges*

Among the significant benefits of globalization in the health sector is the rapid dissemination of medical knowledge and technologies. Advances in medical research, pharmaceuticals, and healthcare innovations can now reach developing countries more quickly, improving disease prevention, diagnosis, and treatment. Telemedicine and digital health technologies have also enabled healthcare providers to offer remote consultations and medical services to underserved areas. Additionally, globalisation has fostered international cooperation in tackling global health challenges, such as pandemics, by enhancing data sharing and coordinated response efforts through organizations like the World Health Organization (WHO).

◆ *Skilled Healthcare Professionals*

Despite these advantages, globalisation has also contributed to the widening gap in health disparities between developed and developing countries. Wealthier nations often attract skilled healthcare professionals from poorer regions, leading to brain drain and shortages of medical personnel in low-income areas. Additionally, the commercialisation of healthcare, driven by multinational corporations, can sometimes prioritise profit over public health needs, resulting in unequal access to essential medicines and services. The rising influence of the global food and beverage industries has also contributed to the growing burden of lifestyle-related diseases such as obesity, diabetes, and cardiovascular conditions.

◆ *Equitable access*

The challenge posed by globalisation is the rapid spread of infectious diseases across borders due to increased travel and trade. Outbreaks of diseases such as COVID-19, Ebola, and the Zika virus have demonstrated how interconnected the world has become, necessitating stronger global health governance and surveillance systems. Ensuring equitable access to healthcare resources, vaccines, and treatments during such health crises remains a significant concern, particularly for low- and middle-income countries.

In conclusion, globalisation has both positive and negative implications for the health sector. While it has enhanced access to medical advancements and improved international cooperation, it has also introduced challenges related to health inequalities, commercialisation, and the spread of diseases. To maximize the benefits of globalization, governments, international organizations, and healthcare stakeholders need to work collaboratively in developing policies that

promote equitable, accessible, and sustainable healthcare systems worldwide.

#### 4.4.2. Privatisation

Health privatisation is changing health services from public to private entities, including private hospitals, insurance companies, and health service providers. This has been an issue of broad debate owing to its many implications for access, quality, and cost of health services.

One central argument for privatisation is the ability to achieve increased efficiency and innovation. Therefore, they are driven by competition and profit maximisation motives, often aiming for higher-quality services. They are most likely to adopt new treatments and thus better take care of the patients. Privatisation will also raise overall efficiency in service delivery since it will apply advanced technologies. Furthermore, the rationale behind privatisation is to reduce the fiscal burden on the government, especially in countries where the public healthcare systems are underfunded and cannot meet the increasing demand.

Privatisation has rapidly expanded in India's healthcare sector. According to the National Sample Survey Office (NSSO) 75th round (2019), more than 70% of urban and 63% of rural households now seek treatment from private health facilities. While private hospitals offer better infrastructure, the average cost of hospitalization is 4–5 times higher than in public hospitals. The NITI Aayog report (2021) warns that 80% of India's population lacks health insurance coverage, leaving them vulnerable to impoverishment due to medical expenses. Moreover, private sector growth has been uneven, concentrated in urban centres, further marginalising rural and tribal populations.

However, privatisation also brings immense challenges, especially concerning equity and accessibility. The most critical concern is that it may result in the exclusion of poor and marginalized groups who cannot afford private health insurance or services. Privatised healthcare systems often show a bias toward patients with the ability to pay for better care, thus increasing the inequalities in health between various socio-economic groups. This may result in a two-tier healthcare system, where the rich enjoy high-class care and the poor are relegated to second-class services.

◆ *Public to Private*

◆ *Increasing Demand*

◆ *Equity and accessibility*



Also, privatisation may commercialize health and thus allow a profit motive to take precedence over patient interest. In such situations, unnecessary treatments or overcharging for certain services could be performed. This orientation toward profitability can lower the emphasis on preventive care or public health initiatives because these cannot generate as much financial reward as disease treatment.

#### 4.4.2.1 Importance of Privatisation

- ◆ *State-Owned Enterprise*

Privatisation or transferring public sector enterprises' ownership and management rights to private entrepreneurs has become essential for achieving efficient economies, improving competition, and spurring innovation. Privatisation is one critical reform for State-Owned Enterprises to enhance performance with fewer bureaucratic inefficiencies and make a business-friendly approach more potent. Privatisation allows governments to focus on core functions such as policy-making and regulation. At the same time, the private sector brings expertise, investment, and efficiency to industries and services previously under government control.

- ◆ *Efficiency and productivity*

The main advantage of privatisation is efficiency and productivity. Private enterprises are profit-driven, which leads to better resource allocation, cost-cutting measures, and enhanced service delivery. Public sector enterprises are often restricted by bureaucratic red tape and political interference, while privatised businesses operate with greater flexibility and responsiveness to market demands. Improved efficiency can lead to better quality products and services, increased customer satisfaction, and higher overall economic growth.

- ◆ *Financial Support*

Privatisation also helps in reducing the financial burden on governments. State-owned enterprises often require significant financial support to cover operational losses and maintain infrastructure. By privatising such entities, governments can reallocate resources to essential sectors such as healthcare, education, and infrastructure development. Additionally, privatisation attracts foreign and domestic investments, boosting economic growth and creating new employment opportunities. The private capital inflow can help modernize industries, adopt advanced technologies, and expand production capacities.

Another important aspect of privatisation is increased competition in the market. When state monopolies are privatised, multiple private players enter the market, leading to a competitive environment that drives innovation and

◆ *Cost Reduction*

cost reduction. This competition encourages businesses to adopt customer-centric approaches, improve operational efficiency, and introduce new products and services that cater to diverse consumer needs. As a result, consumers benefit from better choices, improved quality, and lower prices. Moreover, privatisation fosters accountability and governance in organizations. Private sector companies are accountable for market discipline, shareholder scrutiny, and performance evaluations, encouraging transparency and result-oriented management. Public sector enterprises may suffer from inefficiencies because of the lack of competition and oversight. Therefore, privatisation can lead to adopting best management practices, performance benchmarks, and corporate governance standards that ultimately benefit stakeholders and the economy.

Despite its advantages, privatisation must be implemented cautiously to safeguard public interests. Regulatory oversight, fair pricing, and access to essential services for disadvantaged populations must be carefully managed to prevent negative social impacts. To ensure equitable service delivery, governments must balance privatisation and public welfare in healthcare, education, and utilities.

#### 4.4.3 Patents and Poor

◆ *Health Technologies*

The situation with patents is such that, concerning poor patients, it is complex and often fraught with problems regarding access to healthcare. Patents for medical products, including pharmaceuticals, medical devices, and diagnostic tools, are designed to be an incentive for innovation, giving exclusive rights to the product manufacturer for a set period. While this encourages new treatments and technologies, it also produces significant barriers for low-income patients. The issue of patents and access to healthcare in India is profoundly shaped by global capitalist frameworks that commodify life and health, a dynamic critically examined by Kaushik Sunder Rajan in his seminal work *Biocapital: The Constitution of Postgenomic Life* (2006). Rajan introduces the concept of bio capital to describe how biomedical and pharmaceutical innovations, ranging from drugs to diagnostic tools, are embedded within global finance systems, speculation, and market valuation. Under this framework, health technologies are no longer viewed merely as public goods or humanitarian necessities but as capital-intensive assets that generate profit.

The understanding is particularly relevant in the Indian context post-2005, following the country's compliance with



◆ *Bio capitalist system*

the TRIPS (Trade-Related Aspects of Intellectual Property Rights) agreement. The enforcement of patent laws under TRIPS significantly altered the accessibility landscape by granting multinational pharmaceutical companies exclusive rights to life-saving medications. As a result, patented drugs often became 5 to 10 times more expensive than their generic counterparts, severely limiting access for low-income patients (Médecins Sans Frontières, 2022). Rajan's analysis helps frame this as not merely a consequence of legal frameworks but as part of a larger bio capitalist system where life itself is marketized.

◆ *Encourages new treatments and technologies*

Rajan's concept of a "regime of ethical variability" further explains how clinical trials, drug distribution, and pricing strategies differ depending on a country's market potential, rather than on public health need. This leads to selective investment in diseases that yield higher returns and neglect of those that predominantly affect the poor. In India, despite having the provision for compulsory licensing, its application remains minimal due to geopolitical pressures and trade negotiations, thereby reinforcing market domination over human rights. By analyzing healthcare through the lens of bio capital, Sunder Rajan underscores the structural inequalities in global health systems. The Indian case exemplifies how access to medicines is governed not just by science or policy but by deeply entrenched capitalist interests, making healthcare a domain of profit rather than a basic human right.

◆ *Issued compulsory licenses*

One glaring issue is the high cost of patented medicines. Pharmaceutical companies holding patents over lifesaving drugs often price them very high; hence, treatments are unaffordable for poor people. This particularly becomes a problem in developing countries where diseases like HIV, tuberculosis, and malaria are prevalent. Poor patients may have to forgo the necessary medications or seek them from substandard or counterfeit sources, leading to treatment failures and risks of resistance. In these cases, governments and non-governmental organisations have sometimes negotiated lower prices or issued compulsory licenses to produce generic copies of patented drugs. However, this has often meant legal challenges by patent holders, further complicating efforts to make cheap healthcare available to people experiencing poverty.

Patents of medical devices and technologies can further

◆ *Affordable access*

block access to important health innovations. Diagnosis tests, vaccines, and surgical instruments can be patented, raising prices beyond the reach of underfunded health systems in low-income regions. Lack of affordable access to such technologies is one of the contributory factors to higher mortality rates and poorer health outcomes among underprivileged populations. In light of these inequities, calls for reforms within the patent system have come from global health organisations, governments, and various advocacy groups. These range from supporting patent flexibilities to ensure affordable access for poor people to life-saving essential medicines and technologies through compulsory licensing or parallel importing. Public-private partnerships and subsidies for developing countries are also of the essence in narrowing such gaps in healthcare access caused by patents.

◆ *Right to health*

A fundamental human right, well recognized at international levels by the United Nations and the WHO, is the “right to health.” This right has developed from the premise that there is an inherent entitlement to receive healthcare services. This entitlement would be accessible to all, regardless of socioeconomic status, enabling healthy living. The right to health is not only about the availability of health facilities but also about services, approachability, affordability, and the quality of service at the facility level. Health is indispensable in realizing other human rights, and it affects all aspects of life, from workability to full participation in society.

◆ *International level*

It is taken that, in practice, the right to health is embodied in various international human rights treaties and national constitutions. The Universal Declaration of Human Rights and the International Covenant on Economic, Social and Cultural Rights include health as a human right, even giving a detailed pronouncement: Everyone has the right to the highest attainable standard of physical and mental health. These instruments demand that health care be provided on a non-discriminatory basis for an integrated provision which includes prevention, treatment, and the social prerequisites of health: clean water, sanitation, education, and housing.

This right, however, is complicated to realize, especially in low- and middle-income countries where the health systems are either underfunded or inefficient. Even in wealthy countries, unequal opportunities to access care are often driven by income, gender, race, and geographical

◆ *Social determinants of health.*

location. In such a scenario, members of underprivileged groups generally face barriers to essential health services, leading to inequalities in health and poor health outcomes. The government has to respect the right to health through appropriate health system financing, ensuring inclusiveness in health policies and access to health care. This may also include reducing health inequities by increasing basic healthcare access in disadvantaged regions, making essential medicines more affordable, and supporting policies relevant to social determinants of health.

◆ *Cost of healthcare service*

Health insurance can be defined as a system meant to assist individuals or groups in paying the costs of healthcare services. In return for a premium, insurance providers agree to pay part or the entirety of a person's medical expenses, depending on the terms of the policy. Health insurance plays a critical role in reducing the financial burden of medical care by covering doctor visits, hospital stays, surgeries, medications, and preventive services.

◆ *Publicly financed system*

Health insurance systems vary in a variety of types globally, and the models vary depending on each country. For instance, in most countries that have attained UHC, such as the United Kingdom, the government usually provides health care through a publicly financed system, often referred to as the National Health Service or NHS. While private companies principally offer health insurance in the United States, special government programs, such as Medicaid and Medicare, insure certain groups within the general population, like the poor and elderly.

◆ *Individual or group converge*

Health insurance generally works in one of two ways: individual insurance, where a person buys coverage directly from an insurance company, or group insurance, where the individual's employer or group organization often supplies the coverage. Group insurance is usually cheaper because it spreads the risk across many people, reducing the premium for each participating person. Most insurance plans have deductibles, co-pays, and out-of-pocket maximums. The deductible is the amount an individual pays for health-related care before insurance kicks in. After meeting a deductible, an individual might be expected to pay part of their medical expenses co-pay before they reach their out-of-pocket maximum; after that, all costs are covered by the

insurance provider.

Health insurance plays an important yet highly differentially delivered and accessed role in affording access to healthcare and offering protection against the high costs of medical care. The coverage level markedly modifies the extent of health insurance's ability to generate better health outcomes, the premiums' size, and the network of providers under the plan.

#### 4.4.4. Consumer Protection Act

◆ *Legal framework*

The Consumer Protection Act (CPA) has played a pivotal role in safeguarding consumers' rights and interests in India, protecting them from unfair trade practices, defective goods, and deficient services. Originally enacted in 1986, the Act established a legal framework to ensure consumer justice. Recognizing the evolving needs of modern consumers, the Act was revised in 2019 to provide a more efficient and timely grievance redressal mechanism. The revised CPA introduced significant changes, including the establishment of Consumer Disputes Redressal Commissions at the district, state, and national levels. These commissions facilitate easier access to justice for consumers by allowing complaints to be lodged without the procedural complexities and expenses typically associated with traditional courts.

◆ *Quality medical care*

A landmark aspect of the CPA is the inclusion of healthcare services within its ambit, recognizing patients as consumers entitled to quality medical care and protection against negligence. This move empowered patients to seek legal recourse against medical malpractice and deficient healthcare services. According to data from the National Consumer Disputes Redressal Commission (NCDRC), there has been a steady increase in medical negligence cases, with over 1,500 cases filed in 2022 alone, underscoring growing awareness and utilization of legal protections among healthcare consumers.

◆ *Systemic Challenges*

However, despite these legal provisions, significant barriers persist, especially for vulnerable groups. Research by the Commonwealth Human Rights Initiative (CHRI) reveals that less than 10% of medical negligence cases come from rural and low-income populations. This disparity highlights systemic challenges, such as lack of awareness about legal rights, fear of litigation costs, and lengthy judicial processes, which limit equal access to justice. These factors often deter marginalized communities from pursuing claims,



undermining the CPA's effectiveness in protecting all healthcare consumers equitably.

◆ *Various Legislations*

While the Consumer Protection Act, particularly after the 2019 revision, marks a critical step forward in patient rights and consumer justice, it also reveals the need for broader systemic reforms. These include increasing legal literacy, reducing judicial delays, and strengthening institutional support to ensure that the CPA fulfils its promise of accessible and affordable protection for all consumers, regardless of socioeconomic status.

◆ *Protecting consumers' interests*

Some of the unique selling propositions of the act are recognition of consumer rights to safety, information, choice, redressal of grievances, and protection against unfair trade practices. Given the increasing impact of online shopping, the 2019 amendment provided for e-commerce and digital transactions. The new act also introduced heavier fines for misleading advertisements and liability for celebrity endorsements.

◆ *Ensuring fair market competition*

The Consumer Protection Act facilitates the process of dispute resolution by allowing complaints to be filed electronically and allowing video conferencing facilities during hearings. It also powers central authorities to review complaints and take appropriate actions, ensuring market transparency and accountability. The act balances consumer rights and business interests in areas such as misleading advertisements, overpricing, and other unfair trade practices. It encourages businesses to adopt ethical practices and improve customer satisfaction, building trust and ensuring fair market competition. Essential legislation ensures equal opportunities for access to justice and freedom from exploitation.

◆ *E-commerce*

#### 4.4.4.1 Salient Features of the Act

The New Act equips the machinery to meet emerging challenges like e-commerce, telemarketing, misleading advertisements, etc. and ensures efficiency in grievance redressal.

**Inclusion of e-commerce :** The earlier Act did not specifically include e-commerce transactions. The New Act has addressed this lacuna. 'e-commerce' and 'electronic service provider' have been defined under the Act. 'E-commerce' is defined as buying or selling goods or services, including digital products, over digital or electronic networks. The

central government has been authorized to take measures and make rules to prevent unfair trade practices in e-commerce.

◆ *Online and Offline*

**a. Broader Definition of Consumer:** The definition of 'consumer' under section 2(7) is broader and includes offline and online transactions. The ambit of the consumer has been widened to cover not only online transactions but also telemarketing and multi-level marketing, which will impose responsibility at all levels.

◆ *Video conferencing*

**b. E-Filing of Complaints:** The New Act (CPA 2019) also enables consumers to file complaints electronically and to hear and/or examine parties through video conferencing. This ensures procedural ease and reduces inconvenience and harassment to the consumers.

◆ *Consumer rights*

**c. Establishment of Regulators for Consumer Protection:** The New Act (CPA 2019) provides for establishing the Central Consumer Protection Authority (CCPA) to regulate matters relating to the violation of consumer rights and unfair trade.

◆ *Consumer commissions*

**d. Unfair Trade Practices:** The New Act (CPA 2019) introduces a specific broad definition of Unfair Trade Practices, which also includes the sharing of personal information given by the consumer in confidence unless such disclosure is made following the provisions of any other law. **Introduction of Mediation to Resolve Consumer Grievances** The New Act provides mediation as an Alternate Dispute Resolution mechanism, making the dispute adjudication process simpler and quicker. This will help with the speedier resolution of disputes and reduce pressure on consumer commissions.

◆ *Product liability*

**Product Liability:** The New Act (CPA 2019) deals with product liability. These provisions, based on strict liability principles, will enable the complainant to claim compensation for the harm caused by defective products or services.

## Summarised Overview

One of the essential components affected by globalisation is the increasing privatisation of health care. This has, in turn, meant that with governments reducing their role in providing healthcare services; private sector involvement has soared, bringing better infrastructure and higher-quality services for those who can afford them while increasing the gap between the rich and the poor. Meanwhile, the privileged part of the population benefits from private hospitals and high-quality medical care. At the same time, the low-income group has to struggle with underfunded, overcrowded public health systems that often lack essential resources. Another primary concern is the issue of patents on essential medicines. Oftentimes, pharmaceutical companies hold patents for life-saving drugs, ensuring their exclusive rights to control the pricing. This has given rise to ethical and economic concerns, mainly in the developing world, where access to affordable medications is paramount. High prices, enabled by patent protections, are unaffordable for many low-income people, furthering health disparities. Governments and health organizations often encourage easing patent laws to make such vital treatments more accessible, especially in low-income and crisis-stricken countries.

The right to health is a universally accepted principle, although significant barriers exist to universal access to healthcare services. While some countries' health systems are developed so everyone can access necessary medical care, many people, mostly in rural and economically weak areas, still face barriers to getting the right services. Further, health insurance systems, devised to protect financially against the high costs of medical care, are generally out of reach for the most vulnerable populations. Health insurance in most developing countries is either too expensive or not available to most of the population, forcing people to bear the cost of health care themselves. The Consumer Protection Act provides legal protection to patients to ensure that health institutions adhere to specific standards of care. The act holds healthcare providers accountable for negligence, malpractice, and exploitation, empowering patients with legal recourse if they suffer harm due to substandard services. Many countries also have consumer protection laws that address overcharging, unlicensed practices, and misleading claims by healthcare providers.

## Self-Assessment Questions

1. Discuss the impact of privatisation on healthcare accessibility, particularly in developing countries. Examine both the positive and negative outcomes for healthcare equity and access.
2. Analyze the effects of patents on essential medicines in limiting the availability of affordable healthcare to low-income populations. Discuss potential solutions to address these barriers.
3. Define the concept of the “right to health” and critically assess how global disparities in healthcare access challenge the realization of this right. Provide examples from different regions.
4. Examine the role of globalisation in exacerbating the healthcare gap between wealthy and low-income populations. Discuss how global economic policies and practices contribute to these disparities.
5. Evaluate the role of health insurance in improving healthcare access, particularly for vulnerable populations. Discuss the significance of health insurance in addressing health inequities.
6. Discuss how the Consumer Protection Act safeguards patient rights within healthcare systems. Critically examine the limitations and challenges in enforcing this protection.
7. Evaluate how governments can balance the interests of private healthcare providers with the need for accessible public healthcare services. Discuss strategies to ensure equitable access to health services.

## Assignments

1. Critically analyze the influence of globalisation on the development and dissemination of medical technologies and innovations across diverse geographical regions.
2. Examine the ethical dilemmas associated with patenting life-saving drugs and evaluate their implications for global public health and access to essential medicines.
3. Discuss how health policy frameworks can be structured to ensure that public and private healthcare sectors contribute to equitable and inclusive access to health services.



4. Evaluate the potential advantages and disadvantages of increased private sector involvement in healthcare delivery within low- and middle-income countries, with special reference to health equity and affordability.
5. Analyze the strategies that resource-constrained countries can adopt to achieve universal health coverage in the context of global economic pressures and healthcare commercialization.
6. Identify the major challenges in enforcing consumer protection laws in the healthcare sector and propose policy and institutional measures to enhance accountability and patient safety.
7. Explore how globalisation, health insurance systems, and the legal recognition of the right to health intersect to shape global healthcare access and equity disparities.

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2. Lal, S. K., & Chandani, A. (1987). *Medical care: Readings in medical sociology*. New Delhi: Jainson Publications.
3. Marfleet, P., & Kiely, R. (Eds.). (1998). *Globalisation and the Third World*. London, UK: Routledge.
4. Spoor, M. (Ed.). (2004). *Globalisation, poverty and conflict: A critical 'development' reader*. London, UK: Routledge.

## Suggested Reading

1. Oommen, T. K. (1978). *Doctors and nurses: A study in occupational role structure*. New Delhi: Macmillan.
2. Parsons, T. (1951). *The social system*. Glencoe, IL: Free Press.
3. Pokama, K. L. (1994). *Social beliefs, cultural practices in health and disease*. New Delhi: Rawat Publications.



## Space for Learner Engagement for Objective Questions

Learners are encouraged to develop objective questions based on the content in the paragraph as a sign of their comprehension of the content. The Learners may reflect on the recap bullets and relate their understanding with the narrative in order to frame objective questions from the given text. The University expects that 1 - 2 questions are developed for each paragraph. The space given below can be used for listing the questions.

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