

# Chapter 2

## Conceptual Approaches to Examining Health Inequities

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**Abstract** This chapter maps key conceptual frameworks in the study of health inequities. Using the dominant approach in the public health literature termed the *risk factor* approach as a reference point; the chapter highlights the key critiques of this approach. These key critiques include the differentiation between the *causes of disease* and the *causes of causes*, the demand to move from demonstrating associations to exploring and defining mechanisms and a critical interrogation of the labels being used. Through a mapping of various frameworks drawn from diverse fields, the chapter presents conceptual approaches which contribute to the filling of these critical gaps in the mainstream public health literature. The chapter ends by identifying the recently articulated frameworks like the ecosocial theory and the intersectionality lens as having attempted to engage with health inequities in a more nuanced fashion and with more depth, and as representing the best conceptual theories we have presently to research this area. We ask in the review and critique that forms the core chapters of the book, how this literature and these frameworks have informed the research being reviewed? We also ask how these insights can help make newer sense by reading across the research in an attempt to delineate what the present literature implies about possible mechanisms as well as gaps in research.

**Keywords** Conceptual framework • Risk factor approaches  
Ecosocial theory • Intersectionality • Social determinants of health

### 2.1 Introduction

Inequity in health by class, race/ethnicity, gender and other axes of power is well established. Inequity has been shown to be present not only in health outcomes, but also in terms of access to health services including in the design of healthcare

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programmes, the availability of health services, the quality of the services provided as well as the investments in and governance of health systems. Thus data today is characterised by increasing divergences along a number of axes (Baru, 2010; Balarajan, Selvaraj, & Subramanian, 2011). Studies have also explored the consequences of societal inequity and health along various axes and of various dimensions upon individuals, groups and of society as a whole (Whitehead, 2000).

The literature provides a large number of approaches to the research on health inequity. These include studies from the perspective of epidemiology and public health; the newly emergent field of social epidemiology; and from various social sciences approaches. In this chapter, I bring together some key conceptual approaches that have engaged with health inequity. The chapter thus also provides the basis to reflect on the theoretical underpinnings of the literature reviewed.

### ***2.1.1 Research on the Causes of Inequity: A Brief Overview***

The recognition of health inequity and its roots in social hierarchies and power differentials is well documented historically. Engels and Rudolph Virchow in the nineteenth century were early precursors (Birn, 2009). Both documented the poor health outcomes among the working class and among the poor living in rural areas, and traced these differentials to their living and working conditions. These early studies done during the pre-germ theory era focused on the larger macro-level observable determinants, and set the tone for subsequent work on health inequities. Subsequent research, however, took a more individualistic turn, probably due to the dominance of the germ theory and the emergent bio-medical view of health and disease.

In India, prior to independence and especially during the discussions on the nature of health systems to be set up in post-independent India, there was recognition of poor health *achievement* among the poor. The British attributed *backwardness* and *traditions* for the very high maternal mortality among Indians. Nationalist leaders on the other hand attributed these poor outcomes to the British rule. These debates continued during the planning of the health systems in newly independent India. The presence of inequity among the population at the time of independence made the reduction of inequity—especially the adverse health outcomes of the marginalised groups a major expressed priority of the government (Amrith, 2007).

Post World War II, the setting up of welfare states in Europe and the Americas paralleled a significant reduction in health inequities by socio-economic classes. However, the need for using multiple approaches to studying inequities in health became apparent by the findings that showed graded health outcomes in the United Kingdom despite universal health care provided through NHS (Blane, 1985). Across the Atlantic in the USA, yearly reviews of statistics on race and class played a similar role to highlight inequity (Krieger, 2012).

In the field of economics there is emerging consensus that the mere presence of or access to an equal set of resources is not sufficient to reduce inequity. Recent theories, particularly Sen's (1999) capability approach interrogate the capacity of individuals and the community to convert these resources or access to resources into actual benefit. According to the capability approach people are able to translate various personal endowments into welfare only if they possess so-called *conversion factors*. Based on this, it is suggested that, "people are only able to turn the financial compensation and other incentives provided by the welfare state into health benefits if they have the right resources (private household or public welfare) at their disposal to do so" (Beckfield et al., 2015, p. 234).

Another major strand is the re-conceptualisation of health equity by linking it with justice. Thus, Whitehead considers health inequity as something unnecessary, avoidable and unjust (Whitehead, 2000). Other scholars link inequity to human rights and social justice (Braveman & Gruskin, 2003), or alternatively to the distribution of power in society (Farmer, 2004). The deepening and sharpening of inequities are also linked to globalisation and particularly the neo-liberal paradigm as described in the first chapter (Kim, Millen, Irwin, & Gershman, 2000; Keshavjee, 2014).

### 2.1.2 Overview of the Chapter

In my reading of the literature, I perceive a dominant *risk factor approach* which draws largely on the definition of individual risk factors which, "has been concerned with associations—and ultimately causal connections and biologic pathways—between individual-level data and (1) social position (especially in relation to social class, race/ethnicity, and gender) and (2) health status (Beckfield & Krieger, 2009, p. 153)." The *risk factor* approach establishes associations between health outcomes and individual characteristics and stops there. Such an approach is reflected in the research conducted after the Black report and summarised in the book *Health Inequality* by Bartley (2004). While the approach has been critiqued extensively, there are three broad strands of the literature which seem to engage with the aspects neglected by the risk factor approach.

One of the key gaps in the *risk factor* approach has been the absence of adequate engagement with the multi-level problem. It was Geoffery Rose who pointed out the difference between *causes of diseases* and the *causes of causes* (Rose, 2001). The second major gap of the risk factor approach was the failure to engage with the concept of *mechanisms* (Bunge, 2004), as distinct from association. These two broad critiques underlined that it was important not only to have some idea about larger macro-level determinants but equally important to theorise about the actual processes or mechanisms that impact health outcomes. Theorising was essential to understand and act upon the phenomenon of health inequity in different settings. Very few approaches engage simultaneously with issues of macro-level determinants as well as mechanisms (at all levels).

The third key critique was with reference to the way labels such as *race* were used in health research. The critique pointed out that it was crucial to understand what a particular label such as race represented in the research study, whether the label was static over time and space (Beckfield & Krieger, 2009; Guru, 2016) and whether it represented a category, a process or a system of production of oppression such as racism (Dhamoon, 2011).

This chapter presents the main body of research that represents the dominant *risk factor* approach in public health (and its various attempts to engage with the critiques) as well as the key conceptual approaches that in my mind have addressed or attempted to address the key critiques noted above. Thus this chapter does not attempt to provide a comprehensive review of the conceptual and theoretical landscape, and is not a chronological journey. It is more a mapping of key ideas put forth by those who engaged with the question of health inequity from the perspective of this author.

## 2.2 The Public Health Approach

### 2.2.1 *The Black Report and After*

Globally the systematic study of disparities in health within nations came to the fore with the Black Report produced by the United Kingdom in 1980. The Black Report led to tremendous debate for its demonstration of a graded inequality throughout British society. One reason for the reaction was the fact that the remarkable institution NHS which provided free services of high quality to all who accessed it for nearly 20 years did not seem to have made an impact on inequity (Bartley, 2004). In the report the authors described the existing inequities and discussed various possible mechanisms that contributed to the inequities (Blane, 1985). The authors of the Black Report had their own opinions on the causes of health inequities but their discussion set off a long and continuing debate on the mechanisms underlying the creation of health inequities. However, this debate has been fuelled by research that was conducted largely in the traditional epidemiological and public health frameworks and relied mostly on the ability to demonstrate associations using regression analysis.

The Black Report and initial explanations suggested by the report led to the establishment of at least five distinct bodies of research on health inequity as described in a book authored by Bartley. In this section, I will describe the main perspectives of each of these explanations. A detailed critique of each of these is beyond the scope of this chapter and for those interested a very good starting point is the monograph by Mel Bartley referred to earlier (Bartley, 2004).

These are

- the materialist explanations.
- the cultural-behavioural explanations.

- the psychosocial explanations.
- the life cycle based explanations.
- the neo-materialist explanations.

### 2.2.2 *The Materialist Explanations*<sup>1</sup>

The materialist explanations simply link various forms of deprivation and inequality in material assets to having an impact on the health of the individual. These were referred to in the Black Report as the, “diffuse consequences of the class structure” which lists various forms of deprivation like “poverty, work conditions and at home” (Black, Morris, & Townsend, 1982). While the material explanations are almost intuitive, what is a challenge to this set of explanations is the almost monotonous and even fine gradation in the health outcomes, when disaggregated along measures of socio-economic status like income quintiles or consumption expenditure. Some authors have come up with explanations based on what they term *organisational resources*, which refer to the differences in power and the consequent differences in exposure to multiple hazards and events in the work place (Wright, 1985).

Scientists have also questioned whether *purely material* advantages will result in such finely graded yet prominent health differences. Some authors talk about the context in which this money is spent as a crucial factor. Money can buy different amounts of things in different contexts (Coburn, 2000). Thus it may well be that such material gaps result not from the fact that there is not enough money per se, but because money spent on goods needed for social acceptability may compete with the amounts available for spending on basic biological needs (Bartley, 2004).

### 2.2.3 *The Cultural–Behavioural Explanations*

While this was one of the explanations suggested in the original Black Report, most research does not seem to have convincingly presented why there may be systematic differences in behaviour between social classes (Bartley, 2004). Concepts such as the locus of control (Bosma, Mheen, & Mackenbach, 1999), Bourdieu’s concept of *habitus* have been invoked to explain the way in which systematic differences in behaviour may occur in different groups of people, which in turn may affect their health (Williams, 1995). A key idea that emerges from this body of work is what has been called the achievement of the *central social role* as defined by a

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<sup>1</sup>We draw on Mel Bartley’s Book *Health Inequality* for descriptions of these five approaches.

particular society (Siegrist, 2000). In this case, it is postulated that all efforts are made to *achieve* or *perform* this role to feel a part of society. Thus, instances where this is not possible such as unemployment for men (whose social role is that of the bread winner), are supposed to lead to negative or even self-destructive behaviours.

These sets of explanations also encompass the notion of shared lifestyles, with community-level adoption of certain behaviours based on the norms evolved in a particular setting, which may vary systematically between groups.

### **2.2.4 *The Psychosocial Explanation***

The key psychosocial risk factors that have been suggested and researched include—social support, control and autonomy, and balance between efforts and rewards both at home and at work.

The psychosocial explanation links these *stressors* sometimes even called the *allostatic load*, with allostasis referring to the processes of the body to keep itself in a stable state (McEwen, 1998), especially through the activation of the hypothalamo–pituitary axis, leading to an increase in the secretion of glucocorticoids. This persistent or over-stimulation of the HPA is suggested as a cause for an increase in a range of disorders based on an activation of the inflammatory process (Brunner, 1997).

### **2.2.5 *The Life Cycle Approach***

The life cycle approach identifies particularly vulnerable points during the life cycle when exposure to hazards will produce particularly long-lasting effects. Deprivations and exposure to hazards during these periods are purported to accumulate over the life time and produce harmful effects even after the situation for the individual changed for the better. This explanation sets out to include the historically accumulated negative events and their effect on the overall health of the individual (Bartley, 2004).

### **2.2.6 *Neo-materialist Explanations***

This set of explanations look at the context within which processes causing inequities in health take place, and suggest that countries that provide more public funding for basic welfare than others, may have less inequity. In other words, while within countries materialist explanations concentrate on the relationship of income and what it can buy to health of individuals, neo-materialist explanations concentrate on the relationship of public provision such as schools and transport to health of everyone in a country.

A response to the above theories noted that

The materialist, cultural-behavioural and psychosocial approaches can help to understand why some people have better or worse health than others when compared within societies. However, without considering these individual- or household-level causes in institutional context, they are of limited utility in explaining why some of these individual-level determinants should vary in their frequency or in their effects across institutional contexts. That is, given a distribution of the social determinants of health and a set of class relations, materialist, cultural-behavioural and psychosocial approaches identify processes that translate these distributions into health outcomes, but these theoretical approaches tend not to problematise the distribution itself. They are also less well equipped to explain how the same individual or household-level causes vary in their effects across institutional settings (Beckfield et al., 2015, p. 230).

## 2.3 The Key Critiques

### 2.3.1 Geoffrey Rose—*The Causes of the Causes*

Rose noted that the causes of the occurrence of the disease in an individual (the individual-level risk factors currently studied in epidemiology) were quite different from the determinants of the distribution of the disease at a societal level (Rose, 2001). We needed to consider multi-level factors to understand the issue of health inequity. This insight also underlined many theories that went beyond the individualistic approach to focus on the way macro-level issues impacted on the distribution of factors leading to the observed patterns of inequity. While socio-economic position, wealth, education, etc. could be associated with health inequities, theories of the *public health approach* did not yet answer the questions of why differences in wealth, education or status arose in the first place.

Association of the individual-level risk factor to the presence of the disease depended crucially on the population-level distribution of the risk factor itself. For example, if hypothetically everyone in a population had a high school education, *high school education* would never emerge as a risk factor even if it were a mechanism of individual risk. Rose further argued the importance of clearly differentiating what he termed as, “causes of disease” from the “causes of causes” (Rose, 2001). While the causes of the disease referred to the individual-level risk factors, the causes of causes he suggested should refer to the determinants of the distribution of these risk factors. These would not be discernible by studies at the individual level, and perforce required studies to look at higher levels. This was the first time the idea of thinking about levels (individual to multi-level) was applied to epidemiological theory and public health issues.

### 2.3.2 *Mechanisms—The Causes of the Causes of the Causes*

Even as there was a move from individual-level thinking to multi-level thinking there was a strong move to explore the actual processes involved in the translation of these statistical associations into the lived reality of societal-level inequity. Towards this Mario Bunge's contribution is significant. By formulating the concept of *systemism* and *mechanism*, he made a huge theoretical leap in the philosophy underlying the journey for the study of health inequity (Bunge, 2004).

Mario Bunge defines a system as something that consists of the following components (the CESM model). The environmental parts that act upon the system or are acted upon by the system; the structure or set of relationships that tie the various components of the system together; and the mechanisms or “characteristic processes” of a given system (Bunge, 2004). What is crucial for the conceptual progress in thinking of health inequity is the tying together of the concept of mechanism and a system. By mechanism he meant, “a process (or sequence of states, or pathway) in a concrete system, natural or social” (p. 186). He further notes that most mechanisms are concealed and thus they cannot be easily observed and measured and have in most cases, to be conjectured. It is this tying together of mechanism and a system that he terms *systemism* (Bunge, 2004).

Bunge's definition of mechanism in social sciences is best elaborated in his own words

Note that our definition pre-supposes a distinction between system and mechanism: the latter is a process in a system. This distinction is familiar in natural science, where one is not expected to mistake, say, the cardiovascular system for the circulation of the blood or the brain with mental processes. But it is unusual in the social studies.... Mechanism is to system as motion is to body, combination (or dissociation) to chemical compound, and thinking to brain. [In the systemic view], agency is both constrained and motivated by structure, and in turn the latter is maintained or altered by individual action. In other words, social mechanisms reside neither in persons nor in their environment - they are part of the processes that unfold in or among social systems.... All mechanisms are system specific, there is no such thing as a universal or substrate-neutral mechanism (Pickel, 2004, p. 176).

To me the concept of mechanism of Bunge has a lot of parallel to the concept of embodiment of Krieger that we discuss later on. His concept of systems and systemism in many ways is parallel to the challenge put forth in the research using the intersectionality framework when they ask us to differentiate between using the label as a category, referring to a process or representing a whole system of oppression (and reproduction of that oppression). Both these are discussed in detail in subsequent sections.

### 2.3.3 *Destabilising Labels*

One of the key developments of the research approaches to inequity has been the invocation of the concept of intersectionality. As mentioned above not only did this



development destabilise labels as such—with the demonstration of heterogeneity in what were earlier considered homogenous entities/groups. Another key issue with regard to these labels is the question on whether their meaning is stable over time and place? This line of questioning is very critical to the study socially constructed and at the same time socially challenged labels like caste in India (Guru, 2016). As Guru argues

First, in times of globalisation, categories such as caste and class are undergoing radical change both in terms of their essence and existence. Second, ....., at the methodological level these categories have lost their conceptual coherence because they have acquired new, perhaps more amorphous, descriptions. [The] third hypothetical claim is that the change in existence is the result of the corresponding change in the essence of these categories (Guru, 2016, p. 21).

With reference to the label of class for example, it has been noted that health researchers have tended to conceptualise social class as “social groups arising from interdependent economic relationships among people set of attributes and material conditions of life of individuals” (Krieger, Williams, & Moss, 1997, p. 345). The empiricist tradition of class as an individual attribute equates class to, “an *observation*, precluding the investigation of unobservable social mechanisms underlying its creation” (Muntaner et al., 2013). A consequence of this view of social class is that it cannot be, “conceptualised, measured or intervened upon at the meso- or macro-levels. Thus, population health disciplines marginalise rich traditions in Marxist theory, whereby *class* is understood as a *hidden* social mechanism such as *exploitation*” (Muntaner et al., 2013).

In the next sections, I will present key theoretical frameworks that to me reflect this philosophical/conceptual journey charted above.

### 2.3.4 In Response—Moving to Multi-level Models

In response to the models that focussed on the individual level, a host of frameworks that emphasised the social production of disease emerged in the 70s and 80s. These including the *Political economy of health* approach had as their core postulate that

any given society’s patterning of health disease - including its social inequalities in health - is produced by the structure, values, and priorities of its political and economic systems, in conjunction with those of the political and economic systems of the other societies with which it interacts, and also the ensemble of available technologies (Krieger, 2011a, p. 167).

This broad strand of thinking drawing its inspiration from the earlier work of those such as Virchow and Engels led to a number of influential theories. These include, theories and approaches such as social production of disease/political economy of health; social determinants of health; fundamental cause; political epidemiology; Latin American social medicine; and health and human rights, which Kreiger (2011a) classifies together as socio-political frameworks/approaches.

### 2.3.4.1 The Political Economy of Health Model

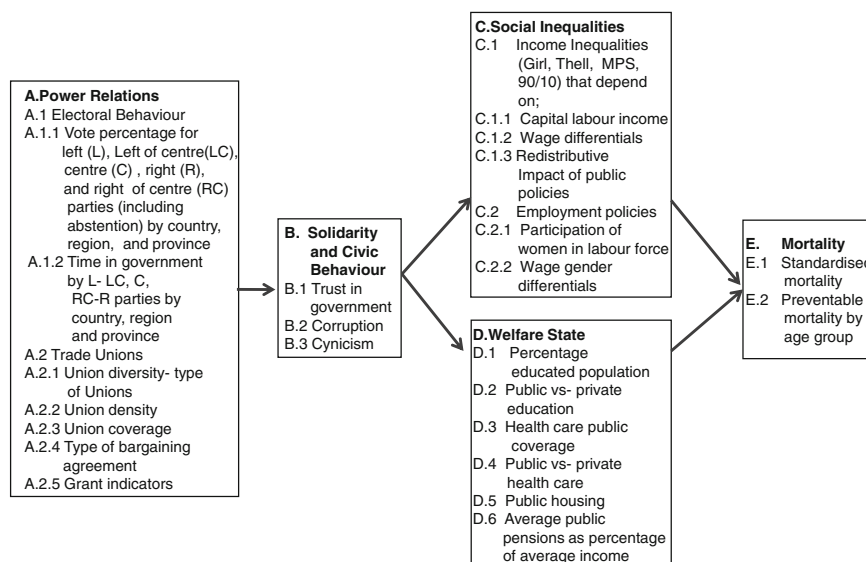
This theory states that in the research on the production of health inequity our focus needs to be on the larger context which imposes many restrictions on choices made by individuals, for example, on lifestyles. Doyal, who gave one of the clearest statements on the theory and wrote a land mark book in 1979 goes on to say that

It is the detailed examination of how the power of capital structures the context in which personal choices are made that must lie at the heart of a Marxist epidemiology. Only in this way can we make sense of the impact of living and working conditions, and pattern of social and economic relationships, on the health of individuals and groups, while at the same time creating the possibility of collective action to transform those conditions (Doyal, 1979, p. 296).

### 2.3.4.2 The Hopkins Model

The Hopkins Model was developed by Vincent Navarro and colleagues who attempted to develop a theory-driven strategy to study the occurrence of health inequities. This model was used to define and study various variables at different levels in an attempt to research inequity in Europe. As shown in the diagram, in essence the model hypothesises four different levels of study. The ultimate outcome studied was mortality (an individual-level variable). The systematic differences in mortality among groups was hypothesised as occurring through the action of social inequalities like income inequalities, wage policies and women's participation in the labour force. This was balanced by a range of factors that attempted to capture the functioning of the welfare state to overcome systematic disadvantage of groups. This set of factors included such variables as percentage educated, public provision of health, public housing, public versus private education, etc. At the next level, it was suggested that this balance between social inequalities and an effectively functioning welfare state depended on the society level solidarity and civic behaviour. This was measured by trust in government, corruption and cynicism. Finally this in turn was attempted to be explained by a range of factors that defined overall power relations in a society—these included electoral behaviour, the activity of trade unions, the type of bargaining agreements, etc. And also governance by different hues of political parties defined as liberal, liberal-Christian, communitarian, etc. (Navarro & Muntaner, 2004).

The Hopkins model not only brought in a multi-level approach, but also attempted to flesh out possible mechanisms based on Marxist theory. The other important contribution of this theory is its delineation of the contribution of politics to health inequity (Fig. 2.1).



**Fig. 2.1** The Hopkins model. Navarro (2004)

### 2.3.4.3 The Diderichsen Framework

An earlier framework from which the Committee on Social Determinants of Health (CSDH) framework draws on is that proposed by Diderichsen and others (Diderichsen, Evans, & Whitehead, 2001). It basically talks about the need for three levels of study.

- Individual risk factors associated with disease. These include age, sex, nutrition, consumption of alcohol, etc.
- These individual-level factors are seen to be clustered around *social position*.
- The distribution of *positions to occupy*; the entry into these *positions*; as well as the modifications of the impacts of occupying these positions are based on the *social context* in which individuals live and the research is being conducted.

The framework defines four mechanisms for the creation of health inequities, and thus four policy entry points for addressing these (Diderichsen et al., 2001).

The four mechanisms suggested are

- “Social stratification (I)
- Differential exposure (II)
- Differential vulnerability (III)
- Differential consequences (IV)”

And the four policy entry points being

- “Influencing social stratification (A)
- Decreasing exposures and vulnerability (B & C)
- Preventing unequal consequences of ill health (D)”

It may be noticed that entry points B, C and D are all functions of the health system, while A is concerned with advocacy that the health system needs to do, in the way of Health in ALL policies (for example).

### 2.3.4.4 The Framework of the Commission on the Social Determinants of Health

By far the most extensively discussed framework in the literature is the framework suggested by the Commission on Social Determinants of Health (CSDH). The CSDH framework is shown in Fig. 2.2.

There are three elements in the framework. The first element of the framework at the far left end—the structural determinants of health—consists of the macro, national level factors including governance, macroeconomic policies, social and public policies and cultural and societal values. The second element of the framework is social position, determined by social class, race/ethnicity, gender and factors determining socio-economic position such as education, occupation and income. The first element contributes to the second element and is in turn, influenced by it. The first and second elements are constituted of what we may call the *structural determinants* of health and health inequities.

The third element of the framework is constituted of the *intermediary determinants* of health and health inequities. These are factors such as material conditions within which individuals live and work, behavioural and biological factors,

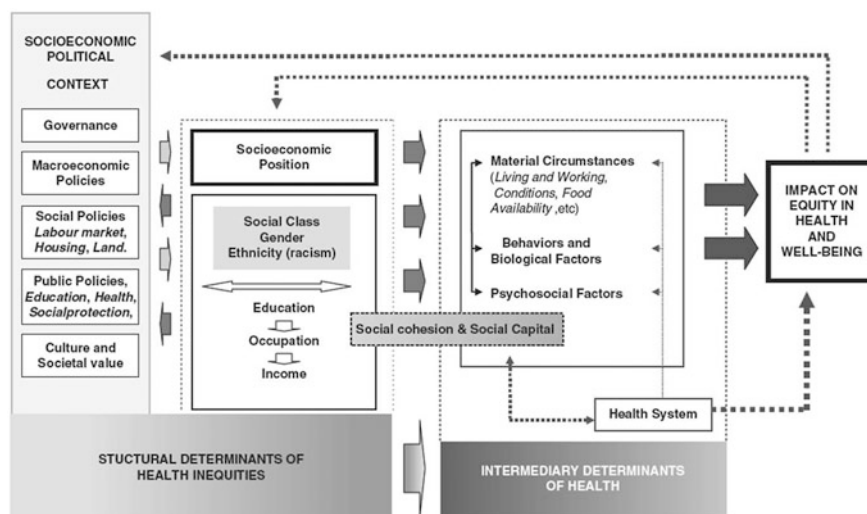


Fig. 2.2 The CSDH framework. Solar and Irwin (2010)

and social cohesion. Social position and its influence on access to resources and capabilities such as education and income influence these intermediary factors. The interaction results in differential exposure to risks of illness and differential vulnerability to health.

The health system is an important intermediary determinant of health. The affordability, access, acceptability and quality of the services delivered through the health system determine the distribution of health and well-being within a population (Sanneving, Trygg, Saxena, Mavalankar, & Thomsen, 2013).

While the CSDH report *Closing the gap in a generation* did indeed bring to prominence the critical role of the social determinants of health, the link to larger macro-level features of a system and the role of the health system as a crucial determinant, it has been criticised for not taking the theorisation far enough. Critics point out that while the report points out that inequality kills, in fact, “it is not inequalities that kill, but those who benefit from [and perpetuate] the inequalities that kill (Navarro, 2009, p. 15).” Similarly it was pointed out that there was no attempt in the report to examine why the policies that were advocated in the Alma-Ata declaration and were again reiterated in the CSDH report failed in the first place, and why nearly 30 years after Alma-Ata health inequities were getting worse (Obregón, 2008; Irwin & Scali, 2005 as quoted Birn, 2009). Most importantly the critics point out that, “If the report echoes Virchow’s understanding of the critical factors shaping health and disease—and does a magisterial job of documenting the existence and consequences of health inequity—it is unlike Virchow, profoundly apolitical (Navarro, 2009, p. 15).” The report did not say anything on what created inequity in the first place. In sum, while the CSDH framework did a lot to bring to fore the multi-level and the social determinants of health inequities, it did not do enough foreground an understanding of systems and root mechanisms that lead to health inequity in a society.

### 2.3.5 *Link and Phelans’ Fundamental Cause Theory*

In contrast to the CSDH framework, Link and Phelans’ fundamental cause theory talks specifically about the macro-factors and defines explicit social mechanisms.

The theory suggests that the fundamental cause influences multiple disease outcomes, meaning that it is not limited to only one or a few diseases or health problems. Second, it affects these disease outcomes through multiple risk factors. Third, fundamental social causes involve access to resources that can be used to avoid risks or to minimise the consequences of disease once it occurs. Finally, the association between a fundamental cause and health is reproduced over time via the replacement of intervening mechanisms. It is their persistent effect on overall health in the face of dramatic changes in mechanisms that led us to call them *fundamental* (Phelan & Link, 2013, p. 106).

Deeming specific risk factors to be in the category of superficial causes, it instead emphasises, as fundamental causes, *flexible resources* including money, knowledge, power, prestige, and social support and social networks (Link & Phelan, 1996;

Phelan, Link, & Tehranifar, 2010). These key resources can be used no matter what the risk and protective factors are, in a given context. Because these resources can be used in different ways in different situations, they are referred to as flexible resources. According to the theory of fundamental causes, the reason that socio-economic position is related to multiple disease outcomes through multiple pathways that change over time is that individuals and groups deploy different sets of resources to avoid risks and adopt protective strategies, in different situations and contexts.

In a further addition to the Fundamental Cause theory, Freese suggests a set of four meta-mechanisms that help to further explicate the social mechanisms involved (Freese & Lutfey, 2011). These include the following—"the first metamechanism, *means*, overlaps most strongly with Link and Phelan's concept of resources. In this metamechanism, an individual purposefully uses his or her socio-economic resources, or means, to improve his or her health... *Spillovers* (the second metamechanism), described previously as contextual resources, occur when other people in an individual's social network purposefully use their resources to benefit their own health, and these efforts produce health benefits for the individual without any purposeful action on the individual's part... Freese and Lutfey's third metamechanism is *habitus*, whose role in health inequities was developed by Cockerham (2005). The fourth metamechanism lies in the actions of *institutions*. Lutfey and Freese refer here not to individuals' utilisation of or access to health-related institutions but to the agentic, dynamic action of institutions that treats people differentially according to their socio-economic positions in ways that affect health inequities" (Phelan & Link, 2013, p. 108).

### 2.3.6 Theories from Political Sociology

While the awareness of the role of political systems in health inequities is not new, the incorporation of this insight into research methods is relatively recent. The Hopkins Model suggested by Navarro and others is one good example of this approach. There are other theories in the broad field of political sociology that attempt to do this. This field has a different orientation as pointed out by Krieger who noted that "its orientation is in contrast to the more conventional epidemiologic approach of treating these categories and social relations as static *risk factors* construed as properties of an individual (Beckfield & Krieger, 2009, p. 153)." In this range of theories we find allusion to *welfare regimes*, *power constellations*, *varieties of capitalism* and *political-institutionalism of inequality* (Beckfield & Krieger, 2009). In this approach the welfare regimes refer to the three worlds of welfare capitalism—liberal, social-democratic and conservative (Esping-Andersen, 1990). Power constellations refer to the political parties in a central way (Moller, Huber, Stephens, Bradley, & Nielsen, 2003), varieties of capitalism refers to the "varied roles of employers and employees in welfare politics and policy within the context of international market competition" and the political institutional approach considers how, policy domains usually considered outside the realm of welfare

economics, such as the penal system and the education system, also have implications for inequality (Beckfield & Krieger, 2009).

Social inequalities in health are persistent, but also vary, across time and geography. Building on research that documents this, recent research has focussed on the welfare state as a possible explanatory factor in the search for causes of health inequity. Such research posits an institutional theory that conceptualises the welfare state as an institutional arrangement—a set of *rules of the game*—that distributes health. “Drawing on this institutional approach in stratification scholarship, four mechanisms are hypothesised as connecting the welfare state to health inequalities by producing and modifying the effects of the social determinants of health. These mechanisms are: redistribution, compression, mediation and imbrication (or overlap)” (Beckfield et al., 2015).

This institutional theory, still undergoing development, suggests that inequality in some variable Y can be explained in part by institutional factors that (i) shift Y from people who have more Y to people who have less Y (or vice versa, through regressive taxation), (ii) limit how low or high Y can go for different population groups or (iii) affect other variables such as X that themselves affect Y and its *distribution* (Beckfield et al., 2015). These theories thus not only attempt to link the political context to the production of patterns of health-related inequity, but also attempt to tease out particular mechanisms as they identify specific aspects of this context to study.

### 2.3.6.1 In Summary—From Causes of Causes to Causes of Causes of Causes!

In his critique of the purely individual and risk factor based theorising, Geoffery Rose pointed out pithily the difference between the causes of the disease (risk factors at the individual level) and what he termed as “causes of causes” or the determinants of the distribution of disease in a given society. What is broadly referred to the social determinants approach (and includes the CSDH framework as its most recent iteration) viewed the social determinants of health as arising from a, *social environment*, “structured by government policies and status hierarchies, with social inequalities in health resulting from diverse groups being differently exposed to factors that influence health (Krieger, 2011a, p. 185).” Thus SDH represent the causes of causes of Rose.

As noted, the “social distribution of causes of causes is a function of institutional arrangements that vary systematically across societies. For example, collective bargaining institutions profoundly affect working conditions and unemployment, and welfare states structure access to goods, services, housing, health care and education by defining some and not others as among the social rights of citizenship... Thus, institutional arrangements explain not only the distribution of the social determinants of health, but also account for how and why the social determinants vary in their effects across institutional settings” (Beckfield et al., 2015, p. 235).

While the political economy approach was *political* in recognising political systems and power differentials, it was relatively silent on the biological pathways that linked these to patterns of inequity including the individual level. On the other hand, the CSDH framework and the Fundamental cause theory, talked explicitly about the biological (CSDH) and social mechanisms (fundamental cause theory), but crucially did not engage in political and economic analysis as to whose interested were being served by the inequities; nor did they draw attention to the pressure exerted by the status quo to reinforce existing inequities (Krieger, 2011a).

To counter the increasing tendency to focus solely on individual resources to the neglect of societal-level conflictual political-structural determinants of health inequities, some epidemiologists have begun to use the more expansive term, “societal determinants of health”. Societal determinants of health are

political-economic systems, whereby health inequities result from the promotion of the political and economic interests of those with power and privilege (within and across countries) against the rest, and whose wealth and better health is gained at the expense of those whom they subject to adverse living and working conditions; societal determinants of health thus become the causes of causes of causes (Kreiger et al., 2010, p. 748).

One theory that has attempted to take all of these criticisms into account is discussed next.

### 2.3.7 *The Ecosocial Theory of Nancy Krieger*

This is an epidemiological theory that attempts to systematise the inquiry into the societal distributions of health and determinants of health (Fig. 2.3).

(The ecosocial theory) postulates that people literally incorporate the reality they live in, in their bodies. This occurs through various mechanisms that are determined by the distribution of power in the particular society. It exhorts us to ask “who or what drives the current and changing patterns of social inequities in health?” and speaks of both the accountability and agency of various actors (including the health system). The theory also stresses the fact that those who have knowledge and power to make decisions need to be held accountable for their stands or the lack of them (as the case may be) (Kreiger, 2011b, p. 215).

The core constructs of the theory refer to processes conditional upon extant political economy and political ecology. These include *embodiment* which refers to how we literally incorporate, biologically, in societal and ecological context, the material and social world we live in; *pathways of embodiment* which include a range of pathways including economic deprivation, exogenous hazards, degradation of ecosystems, targeted marketing of harmful substances, etc.; *cumulative interplay of exposure, susceptibility, and resistance across the life course* and *accountability and agency*, which refers to the responsibility of the researchers and those in power to make change to explain these inequities and make the necessary changes the players are empowered to (Krieger, 2011a).



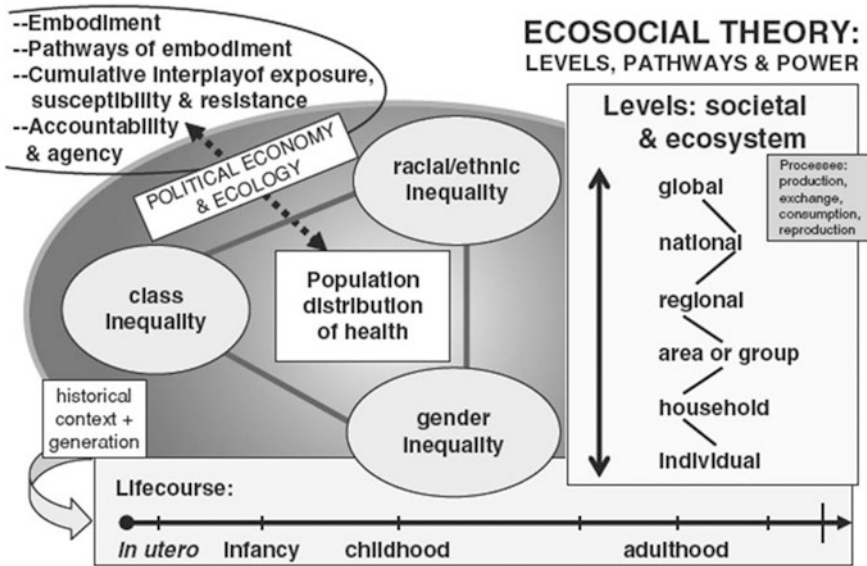


Fig. 2.3 The ecosocial theory framework. Krieger (2011b)

Apart from the core tenets referred to above the other tenets of the theory are (Krieger, 2011a)

- Determinants of current and changing social patterns of disease distribution, including health inequities are: (1) exogenous to people's bodies; (2) manifest at different levels and involve different spatiotemporal scales.
- Explanations of disease cannot be reduced solely to explanations of disease mechanisms, as the latter do not account for why rates and patterns change in complex ways over time and place.
- There needs to be a more reflexive epidemiology which situates the investigations motivating theories, hypothesis, analytical methods and interpretations of the investigator in the broader social context.

The ecosocial theory explicitly starts by striving to identify the drivers of the *causes of causes* by asking who or what drives the present distribution. Further by invoking the concept of embodiment it focuses on the mechanisms by which the social arrangements are imprinted on biology. There has been some interesting research that explicitly uses this theory, and such research is beginning to provide some insights into the way structures impact on biology. Thus in a recent study on immigrant's oral health the authors note, "Taking a critical medical anthropological approach, we argue that studies of embodiment must take into account the ways that socio-economic circumstances and public policies—not just culture—are physically embodied (Horton & Barker, 2010, p. 200)." In their study of oral health disparities

among Mexican-American farm-worker children, Horton & Barker observe that the children's social vulnerability was physically embodied in the form of malformed arches and crooked teeth. An underfunded public health system and non-coverage of oral health by public insurance schemes cement the enduring effects of their social disadvantage, by creating a group whose bad teeth made them stand out as belonging to an underinsured class, finding their upward social mobility hindered by their distinctive bodily markings (Horton & Barker, 2010).

### 2.3.8 Intersectionality

#### 2.3.8.1 Theoretical Considerations—Intersectionality

Born from the lived experiences of marginalised women who found that only parts of their identities were being addressed in the current social movements, intersectionality emerged as a key lens or framework that is challenging the mainstream *risk factor* approaches to the study of inequity and its theorisation.

Hankivsky notes that

Intersectionality is concerned with bringing about a conceptual shift in how researchers, civil society, public health professionals and policy actors understand social categories, their relationships and interactions. It requires a consideration of the complex relationship between mutually constituting factors of social location and structural disadvantage so as to more accurately map and conceptualise determinants of equity and inequity in and beyond health (Hankivsky & Christoffersen, 2008, p. 18).

Researchers and activists who were intimately involved in women's struggles for basic livelihood, survival and dignity like those involved in the anti-race movement in US (Crenshaw, 1991; Purkayastha, Subramanian, Desai, & Bose, 2003) and in the various struggle for access to social resources in India in the 90 s argued against treating women as a homogenous entity and emphasised that it was crucial to grasp interactions of class, gender, caste, religion and regional specificities in order to understand the conditions of women and men (Purkayastha et al., 2003).

The key theoretical contributions of the concept of intersection of multiple axes are

First, it changes the relationship between the categories of investigation from one that is determined a priori to one of empirical investigation ... Second, intersectionality posits an interactive, mutually constitutive relationship among these categories and the way in which race (or ethnicity) and gender (or other relevant categories) play a role in the shaping of political institutions, political actors, the relationships between institutions and actors, and the relevant categories themselves (Hancock, 2007, p. 67).

Moreover, Hancock specifies that intersectionality is based on the idea that it was important to analyse more than one category; that individuals even within the same category were different; that no one category may be a priori considered as more important than the other; that the relationship between the different axes was

to be understood through empirical investigation within a specific spatial and temporal location; that there existed a dynamic interaction between individual and institutional factors, because of which the analysis of one should be integrated with the analysis of the other (Hancock, 2007).

Both the race and *dalit* critiques of the universalising nature/aspects of feminism have questioned the erasure of lived experience from what is considered the universal norm, usually derived from a dominant groups or frameworks like *white women* or *brahminical institutions*. Both have demanded that such categories be kept open and based on empirical investigation rather than defined a priori (Rege, 2013; Chakravarthi, 2006).

Some approaches like those of Dhamoon have emphasised the process of formation of the identities and have invoked Foucault. Thus, they point out that in Foucauldian terms, the focus of analysis is not strictly on an individual, a category, a group or an institution (although these are not absent either) but on the techniques of power (Dhamoon, 2011). The “matrix of meaning-making” is a framework that draws on the Foucauldian approach, “It aims to foreground an expanded Foucauldian understanding of power so as to capture the ways in which processes of differentiation and systems of domination interrelate. The focus of analysis is thus not only domination but the very interactive processes and structures in which meanings of privilege and penalty are produced, reproduced and resisted in contingent and relational ways” (Dhamoon, 2011, p. 238).

Another sociologist/philosopher whose approach has been used in the study of inequity and intersectionality is Pierre Bourdieu, especially in his use of the concept of *habitus* and *field* (Anne, Callahan, & Kang, n.d.; McNay, 1999). A praxeological approach has been suggested for the study of intersectionality based on Bourdieu’s work, which suggests that everyday life of people be the starting point of empirical analysis, even as we keep in sight the interrelationships between caste, gender, class and so on (Winker & Degele, 2011). While the simplistic and first stage of methodological development will be the study of the interaction of these various axes, used as individual-level labels, the intersectional approach challenges us to go beyond this interactionist approach to invoke a more complex and dialectical approach that challenges and re-names (Hancock, 2016).

## 2.4 Conclusions

Birn highlights the fact that “(1) evidence of the association between poverty and ill health is long standing; (2) social inequality in health data are interpreted according to diverse theoretical and ideological frameworks; and (3) the ways data are interpreted shape the kinds of action (or inaction) undertaken (Birn, 2009).” Thus the way in which an issue was problematised and theorised impacted on how the data was interpreted and acted upon. This underlines the importance of the conceptual framing of research on health inequity.

This chapter has attempted to map the conceptual terrain of thinking on health inequities. It does this by first presenting the dominant public health epidemiological paradigm and then using the other theories that have been developed to develop a critique of the mainstream. In doing so, three main points were highlighted. One was the need to elaborate on the *causes of the causes of the causes*, the second was to try and decipher mechanisms and the third point was the critique of the labels and variables used in the research process. Despite the presence of these theories in published mainstream literature there seems to be little in terms of these theories shaping methodologies and research agendas.

The almost monotonic increase in inequity along many dimensions of life calls for a serious questioning of the various approaches to the study of health inequities. An editorial to a recent special issue of a journal pointed out the emerging critique of the tendency within research on health inequities to focus on individual categories; the dependence on large data sets for analysing inequities in health, which in turn limited the analysis to categories and variables available within those data sets, and to cross-sectional rather than longitudinal and time-sensitive analysis (Kapilashrami, Hill, & Meer, 2015; Muntaner, Ng, Chung, & Prins, 2015; Scambler & Scambler, 2015). Indeed the editorial sought to, “highlight the need for theoretical frameworks that draw attention to historical processes so that we better understand not just how particular policies impact on health inequalities, but how and why those policies arise (Smith & Schrecker, 2015, p. 222).”

Today the largest proportion of literature is still descriptive, there being relatively little theoretically driven work. Not only are there relatively fewer studies which adopt theoretical approaches, but the few studies that do, apply it to explain existing findings rather than to help find ways of tackling the inequities (Smith & Schrecker, 2015).

In her article using the ecosocial theory to outline a study of discrimination, Krieger points out that

Rigorous methods for the scientific study of discrimination and health require (1) conceptual clarity about the exploitative and oppressive realities of .... forms of discrimination; (2) careful attention to domains, pathways, level and spatiotemporal scale, in historical context; (3) structural - level measures; (4) individual-level measures, albeit without relying solely on self-reported data or reducing discrimination to solely a psychosocial exposure; and (5) an embodied analytic approach (Krieger, 2012, p. 942).

While there are many common aspects of the theories discussed, each contributes something new to the overall discussion. In many ways the ecosocial theory is the most complete articulation of the collective knowledge built over the years.

It is clear that inequities in health arise from a combination of factors acting at multiple levels and result in particular patterns at particular times in history. The factors are a combination of personal genetic material interacting with external factors, the determinants of which depend on social structures. These structures may be institutional—like the public distribution system, the public health system or the educational system—or social—like the hierarchical relations of caste and gender. In our understanding it is these social and institutional structures that combine to

form a *system* that results in health inequities. The interactions of factors happen at different levels. Individual behaviour is embedded in the family, in neighbourhood, in town, in region and so on, and each level, an individual may belong to multiple groups simultaneously. These arrangements are not static but dynamic with historical processes of struggle and negotiation leading to current states of equilibrium which are in reality mere transitions to other states in the trajectory.

We use this understanding of health inequity to guide our reading and critique of the literature pertaining to India. We examine the review from the perspective of whether the rich body of theoretical knowledge has informed health inequities-research being done about India. We also ask in the critical synthesis how these insights can help make newer sense by reading across the research in an attempt to delineate what the present literature says about possible mechanisms as well as the gaps in research.

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