Social Determinants of Health: A Deep Dive into Nepalese and American Societies

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Abstract

Health inequity is a widespread problem created by unequal social, cultural, and economic environments in society. Based on the "fundamental theory of causes," this paper investigates the role of social context (i.e., socioeconomic status (SES), education, gender, ethnicity, and community environment) as an important causal factor in health inequalities. Through comparisons of two different contexts, Nepal and America, the paper emphasizes the systemic conditions that maintain health inequalities in these societies. Although the problem is presented globally, its dynamics are heterogeneous with regard to regional, cultural, and structural circumstances. The study employed the content analysis to examine and compare secondary data, including scholarly articles, government reports, and demographic surveys. Major publications on the determinants of health inequality and region-specific studies in Nepal formed the base of a comparative analysis. Results demonstrate that in the United States, socioeconomic status, systemic racism, and discrimination in access to healthcare are contributing factors to health disparities. In Nepal, caste/ethnicity, regional differences, and patriarchal systems are important factors of impact. Both countries illustrate the impact of social determinants of health on health outcomes, such as care access, dietary practices, and longevity. The conclusion of the study is that reducing health inequality includes tackling social inequality and providing equitable access to resources.

Keywords: health inequality, socioeconomic status, social determinants, Nepal, America

Introduction

Human behavior and health are greatly influenced by the social surroundings in which people are reared. More, as McIntire (1894) pointed out, individuals gain norms, values, beliefs, morals, customs, knowledge, attitudes, and habits from society and are molded by their participation and experience. These social circumstances and exposures not only affect individual behavior and ability but also strongly contribute to the biological and mental health state of men and women. Social environments and conditions play a major role in the formation of habits, behavior, and abilities and an important role in the health outcomes.

Phelan, Link, and Tehranifar (2010) explored social determinants as core contributors to health inequity. Their studies focused on the interplay between variables, including socioeconomic status (SES), gender, education, ethnicity, and knowledge, in their "fundamental theory of causes". They revealed how social and economic inequalities lead to unequal access to resources such as knowledge, power, prestige, and healthcare, in turn generating worse health outcomes. The theory of fundamental causes, first proposed by Link and Phelan (1995), posits that systemic inequalities in social, political, and economic systems perpetuate health disparities by restricting access to technological advancements, medical innovations, and critical health information.

Due to the regular interaction between social determinants of health, health is maintaining and changes in with societal and technological growth. Community and neighborhood geometry play an important role in predicting health outcomes, as people in wealthy communities enjoy access to healthcare services such as facilities, education, and support networks that people in poor communities do not (Phelan et al., 2010). That, in turn, is important in the process of the development of individual health behaviors and effects on health and has a bearing on how social factors underpin health.

In Nepal, as in other societies, caste, ethnicity, level of education, sex, health care access, and socioeconomic backgrounds are inextricably linked to health results. Nepal's rich social, cultural, and economic diversity provides different challenges and opportunities for health equity, marked by variations across geographical locations, cultures, and infrastructures (CBS, 2021).

The purpose of this study is to explore and compare the role of social conditions as fundamental causes of health inequality in Nepal and America. Based on the theoretical model of Phelan, Link, and Tehranifar (2010), this study aims to investigate the systemic inequalities and social determinants that fuel health disparities in those two social domains. By addressing these issues, this study aims to contribute to a better understanding of health inequalities and propose strategies to mitigate them through equitable social and economic interventions.

Methodology

In this paper, using the content analysis approach, I attempted to comprehensively analyze and compare social background as an important root cause of health inequality both in Nepal and the United States. This approach involved a detailed review of existing scholarly literature, government reports, and demographic surveys relevant to the subject matter. In particular, and since they grounded the theory of causes (Phelan et al., 2010), the most significant core texts (see e.g.) were examined in order to understand what is assumed by the theory and its application in the American context. Similarly, early literatures and reports specific to Nepal, such as the ones by the Central Bureau of Statistics (2021) and New ERA (2017), were examined in an attempt to identify trends and problems associated with the health gap represented by socioeconomic status (SES), level of education, gender, ethnicity, and geographical variation.

A deep analysis is made in two contexts based on themes relating to the impact of SES on health care access, the correlation between education and health literacy, and the effects of regional and cultural complexity on health inequality. By going through the literatures, this approach enabled us to show that various social contexts affect health inequality in both Nepal and America. The methodology involved coding and classifying data for the deep analysis of social determinants of health in the two nations. Discussion of the analysis involved examining the effects of social organization, availability of resources, and systems of disadvantage on health contexts, thereby offering a rich and nuanced interpretation of the topic.

Findings and Discussion

Social Conditions as the Root Causes of Health Disparities in the United States

In the American Sociological Association's 50th anniversary program on medical sociology, medical sociologists outlined the grim truth that people at the lower end of the economic ladder are poorer in health and have a much shorter average mortality than those in the higher economic class (Kunst et al., 1998). This evidence also provides a basis for the argument that low social and economic status (SES) is the main route of causation to poor social health. Furthermore, a low level of education is also a major risk factor for poor health and shortened life expectancy in the United States (Phelan et al., 2010).

A fundamental causes theory has been used to account for health disparities caused by SES, education level, race/ethnicity, health care access, neighborhood environment, and livelihood. This theory, first developed by Link and Phelan in 1995, posits that individuals' and groups' ability to utilize knowledge, power, money, prestige, and access to improve health and seek medical care is central to understanding health disparities (Link & Phelan, 1995). Social, political, and socioeconomic disparities described in the core theory of cause and effect illustrate how these issues give rise to disparities in access to the latest technologies, medical treatments, and essential health information.

Community or neighborhood patterns further contribute to health inequalities. Individuals living in affluent communities have better access to health facilities, such as sports clubs, parks for exercise, health clubs, and other services. These communities also have increased access to information and to resources as needed. In contrast, individuals living in poorer communities lack such facilities and access (Cockerham, 2005). Similarly, informal networks at the family or community level also influence health outcomes, with wealthier networks providing better health conditions compared to their poorer counterparts.

Social norms, values, and cultural practices also have an important contribution to the health status of the individuals. Societies that have a strong set of norms for alcohol avoidance, smoking avoidance, and exercise adherence are characterized by good health outcomes compared with societies with a high prevalence of alcohol drinking, smoking, and an informal lifestyle (Phelan et al., 2010).

Even in the creative and effective contextual intervention program for the benefit of overall population, the results of the program is different in the various SES groups if the intervention program is expensive, longer time of involvement and complex (Chang & Lauderdale, 2009). The result of intervention program is more positive to the elite class.

SES is a significant determinant that leads to multi-morbidity of the populations. SES also generates situations considered high risk for disease and even fatality. Nevertheless, access to resources or medical facilities can bridge the difference in SES groups. The association between SES and health status is interactive and changes over time with the development of technologies and medical interventions (Phelan et al., 2010). In this manner, SES plays both a causative role in disease and a fluctuating regulator of health status.

Men involves in the risky and hard work to express their masculinity for better earning and better social position, while women are involved in the less risky and easy work cause the longer life of women than men (Courtenay, 2000). Society has created the masculinity attitudes and superiority feeling in the men than their female counterparts.

Lower SES settlements have a higher risk of death from chronic diseases, communicable diseases, and injuries due to poor sanitation, limited knowledge about diseases, and restricted access to resources. Lower SES individuals are less conscious about their health and often lack a proper diet, leading to problems such as being overweight or underweight. On the other hand, they rarely go to hospitals for screening in early disease stages, and they seldom go to routine health checkup (especially over 40), even after disease onset (Phelan el al., 2010).

SES inequalities brings inequalities in health outcomes in the complicated health cases like heart treatment of HIV/AIDS patient (Goldman & Lakdawalla, 2005). It means in America the patients with having complicated health issues can have better results to the higher economic status people than the lower status people.

The survival rate of disadvantaged minority Americans (i.e., African Americans, Native Americans, and Hispanics) compared with that of White Americans in chronic diseases such as cancer is also shorter. The theory of fundamental cause leading to inequality explains the disparity in survival expectancy between disadvantaged and advantaged racial or socioeconomic strata. The major factor behind such disparity is the economic and knowledge gap. However, the application of the fundamental causes' theory is challenging in the case of older age groups (Phelan et al., 2010).

Causes of death from different diseases are in a state of flux, as due to the introduction of better intervention mechanisms, infrastructure, and healthcare facility availability, death rates fluctuate. Therefore, the results from previous studies may not always be generalizable to designing intervention strategies in the current situation. Alterations in behavioral, as well as daily, habits have their place too. For example, the intervention effect of hormone therapy with the aim of slowing the progression of breast cancer in women over 50 years old has reduced the incidence of women's breast cancer in Whites. But the breast cancer problem in Black women is higher as they have lower or no access to the intervention of hormone therapy. The fundamental causes theory implies that interventions can produce differences in outcome across racial or community groups (Phelan et al., 2010).

Phelan, Link, and Tehranifar (2010) present enough evidence to argue for the mediating role of social conditions as one of the underlying causes of health disparities in America.

Social Condition as the Fundamental Cause of Health Inequality in Nepal

Social circumstances, such as socioeconomic status (SES), residential neighborhood/adjacent community, caste/ethnicity, education, gender, network, availability of health services, and work, act as basic causes of health inequality in Nepal, as they do in the United States. The health condition of populations is strongly affected by the socio-economic, cultural, and political context of the society. Nepal, with its diversity in caste/ethnicity, religion, occupations, ecological regions, cultural values, and development disparities between rural and urban areas, exhibits complex health inequalities. Although a male society, there are cross-cultural differences in the way gender is organized in Nepal. Specifically, the levels of education vary also considerably among ecological areas, provinces, and rural-urban areas (CBS, 2021).

Mortality rate is an important measure of health at the societal level (Sobia, 1977). As an example, male mortality rate is found to be greater than female mortality rate in certain age groups in Nepal, an implication for the hypothesis of Phelan, Link, and Tehranifar (Joshi, 2014).

In the Terai region of Nepal, major settlements include Madhesi, Tharu, and Dhimal communities, alongside other castes and ethnic groups. The hilly area has a population composed of different ethnic and caste communities, and the mountain area is mainly populated by the communities of Bhote, Sherpa, Gurung, Thakal, Tibetan, and Manange. Infant mortality is the least in the hilly area (47), medium in the southwestern Terai region (65), and most in the mountainous region (99) (Pradhan & Pant, 2007). Reasons for the high IMR and unhealthy state of the population in the mountain region are the weak health facilities and background of the mountain region, ancient practices, and poor economic condition. By contrast, the health inequalities are compounded by the context of highly imbalanced gender structures, cultural norms, and socio-economic disadvantage in the Terai region.

The relationship between social conditions and health is dynamic in nature, improving over time with government interventions, innovations in medical technology, and preventive measures. As

an example, Nepal's level of crude death rate reduced from 13.5 in 1981 to 7.3 in 2011, demonstrating the positive role of intervention measures (Joshi, 2014).

There are substantial differences between rural and urban communities concerning economic status, education attainment, physical environment, social connections, access to medical care, and eating habits. Life expectancy at birth is higher in urban areas for both males (70.10 years) and females (71.00 years) compared to rural males (64.9 years) and females (67.6 years) (New ERA, 2017). These inequalities are mainly caused by inequalities in social and economic status. Additional discussion on stunting, anemia, maternal education, and particular provincial data highlights the heavy contribution of socio-economic and cultural differences in explaining health outcomes in Nepal. These patterns closely associated with the theoretical framework developed by Phelan, Link, and Tehranifar.

Conclusion

Human behavior and health are intrinsically tied to social context. The profound influence of sociocultural and economic environments on the individuals determines their personality and health outcomes. Through the processes of socialization, individuals develop norms, values, beliefs, and behaviors that are integrated into their physical and mental states. Yet to be ignored is the fact that humans are not raised in the same kind of environment and social contexts, which leads to the variation in human behavior and health status in the population.

Health correlates are strongly affected by eating habits, family environment, economic condition, access to medical care and access to communication These elements collectively determine the well-being of individuals. However, these important social resources are not evenly distributed in the society. Heterogeneity in the access and distribution of these resources results in significant inequities of health outcomes that, in turn, make social position a central factor of health inequality.

The incisive analysis of Nepal and the United States emphasizes how deeply social factors, including socioeconomic status, education, gender, ethnicity, race and geographic variations, contribute to health disparities. While America shows the evidence of health inequity as a result of systematic racism, socioeconomic gradients, and healthcare disparities, Nepal offers its own burden, in the form of caste in addition to reinforced regional differences and patriarchal social structures. Although contextual variations exist, both cases show the way in which imbalanced social environments produce imbalanced health effects. Therefore, focusing on the social determinants of health and minimizing social inequalities would lead towards alleviating health inequalities and improving health condition of socio-economically lower status people.

References

Central Bureau of Statistics (2021). *Population monograph of Nepal*. CBS, Kathmandu.

Chang, V. W. and Diane S. L. (2009). “Fundamental Cause Theory, Technological Innova tion, and Health Disparities: The Case of Cholesterol in the Era of Statins.” *Journal of Health and Social Behavior* 50:245–60

Cockerham, W. (2005). “Health Lifestyle Theory and the Convergence of Agency and Structure.” *Journal of Health and Social Behavior* 46:51–67.

Courtenay, Will H. 2000. “Constructions of Masculinity and their Influence on Men’s Well-Being: A Theory of Gender and Health.” Social Science and Medicine 50:1385–1401

Goldman, D. P. and D. N. Lakdawalla. 2005. “A Theory of Health Disparities and Medical Technology.” Contributions to Economic Analysis and Policy 4:1–30.

Hallingshead, A.B. (1973). Medical sociology: a brief review. *Health and Society*, 51 (4) 531-542. https://doi.org/10.2307/3349632

Joshi, P.L. (2014). Mortality levels and patterns in Nepal. *Population Monograph of Nepal*, 1, 127-140 Central Bureaus of Statistics, Kathmandu. https://mohp.gov.np/downloads/Population%20Monograph%20V01.pdf

Kunt, A,E., Feikje, G. & Mackenbach, J.P. (1998). Occupational class and cause of specific mortality in middle age men in 11 European countries: Comparison of population based studies. British Medical Journal, 316, (16), 36-42. https://doi.org/10.1136/bmj.3167145.1636

Link, B.G. & Phelan, J.C. (1995). Social condition of fundamental causes of disease. Journal of Health and Social Behavior, 35 (extra issue) 80-94. DOI: 10.1177/0022146510383498

MacIntire, C. (1894). The importance of the study of medical sociology. *Health Sociology*, 9 (1), 425-434.0

New ERA (2017). *Nepal demographic and health survey 2016*. Nepal Ministry of Health, Kathmandu.

Phelan, J.C., Link, G. & Tehranifar, P. (2010). Social condition as the fundamental causes of health inequality: theory, evidence and policy implications. Journal of Health and Social Behavior, 51 (5) 28-40. Sage Publication. Doi: 10.1177/0022146510383498

Pradhan, A. & Pant, P.D. (2007). *Trend in demographic and reproductive health indicators in Nepal*. Kathmandu, New ERA.

Pradhan, A. (2014). Maternal mortality. *Population Monograph of Nepal*. CBS, Kathmandu. https:// mohp.gov.np/downloads/Population%20Monograph%20V01.pdf

Saboia, J. L.M. (1977). Autoregressive integrated moving average (ARIMA) models for birth forecasting. *Journal of American statistical Association*,72, 264-270. http://dx.doi/abs/10.1080/01621459.1977.10480989