VIDIT
PUBLICATION

सत्यमेव जयते

UTTAR PRADESH PUBLIC SERVICE COMMISSION

HEO

HEALTH EDUCATION OFFICER

★

PAPER -2
SOCIAL SCIENCE

SPECIAL FEATURES

- Expertly Curated Content
- Exam Focused Approach
- Simple Language & Clarity
- Updated & Reliable Material

SOLVED PAPERS
THEORY + MCQ's

- Previous Year Questions
- Topic-wise Questions
- New Pattern Based

विदित पब्लिकेशन, प्रयागराज, मो. 8858920081

8. Economics

A Few Words About the Book

This book by **'VIDIT Publication'** has been prepared keeping in mind the latest syllabus and nature of the 'Social Science' paper (Paper II) for the Health Education Officer (HEO) Main Examination conducted by the Uttar Pradesh Public Service Commission (UPPSC). It compiles important facts and concepts related to social issues, demography, health and social welfare, and social research. To assist aspirants, special attention has been paid to incorporating up-to-date government data and maintaining standards aligned with the Commission's requirements.

To ensure maximum utility and benefit, detailed content and analytical information have been included in each section in a manner that facilitates the candidates' preparation and minimizes difficulties during the exam. We express our gratitude to the experts and colleagues who assisted in making this book error-free and of high quality. Despite continuous and diligent efforts, the possibility of inadvertent human errors or omissions remains; therefore, constructive suggestions from discerning readers and aspirants are cordially invited.

Aditya Tripathi

Syllabus for The post of Swasthya Shiksha Adhikari
Screening Exam
Subject - Social Science Related Knowledge

1. **Sociology**

   Health: meaning, theoretical dimensions conflict, functional and interactionist. Health in India - rural and urban gap, malnutrition and poverty, sanitation problems.

   Social dimensions of health; Social factors of health, economic status (rich vs poor), education, occupation, gender and caste, living conditions (urban vs rural).

   Health and culture: food habits, hygiene practices, beliefs and behavior about disease, social responsibility towards illness.

   social prejudice related to diseases (HIV, AIDS, CANCER) etc.

   Health inequalities: class inequality, gender inequality, caste inequality, government policies related to health like Ayushman Bharat, NRHM and its impact on community.

2. **Anthropology**

   Anthropology and its relevance and significance in social science; Human Variation: Tribal, Rural and Urban Population; Public Health: Definition, Parameters, Components, Human Diseases and Health, Genetic and Communicable Diseases, their eradication; Human Blood Groups: ABO, MN, Rh and their applications

3. **Psychology**

   Meaning, methods, scope of psychology & goals, Heredity and Environment, Meaning and law of perception. Learning, Memory & forgetting Classical & instrumental conditioning, Short-term and Long-term Memory, Causes of Forgetting, Nature & Theory of intelligence. Psychological assessment, Motivation & Personality Psychological test, Criteria of motivated behavior, language development, Definition and type of personality. Problems of Contemporary society Drug addiction, The Problems of aged, Stress & Health, Juvenile delinquency

4. **Social psychology**

   Basic Human values and attitude: nature, sources and features of values. Nature, formation and function of attitudes.

   Social Control: Purpose, causes and agencies. Social Change: Problems, causes and theories.

   Communication and persuasive communication: nature, theories, determinants and resistance to persuasion. Social interaction and interpersonal attraction.

   Community health: Nature, types and role of community health. Nature and types of counseling, Yoga and health.

5. Political Science

Indian Constitution: preamble, fundamental rights, directive principles of state policy, fundamental duties.

Government and Politics: Parliament and state legislature- function, power, privileges; Executive- President, Prime Minister, Council of Ministers, Governor and Chief Minister.

Judiciary: Supreme Court and High Court- structure and power.

Local Self Government: Panchayat Raj/Municipalities

Constitutional bodies: Election Commission, Finance Commission, Union Public Service Commission, Comptroller and Auditor General.

Governance and Public Policy: Role of government, non-governmental organizations and civil society organisations in development of social sectors.

6. Geography

Meaning and significance of Health geography; Geographical factors affecting human health & diseases - physical, social, economic and environmental.

Impact of environmental degradation and natural disaster on human health and its management.

Classification of genetic, communicable, non-communicable diseases. Geography of hunger, malnutrition and food security.

Pattern of distribution of major diseases worldwide and in India. Health care planning and policies of India.

7. History

Vedic Literature, Mauryan and Kushana Art, Stupa and Temple Architecture.

Significant events of Modern Indian History specially freedom struggle.

Integration of Princely States and re-organization of States after Independence.

Important events of World history between 18th and 20th century - French revolution, Industrial revolution, First and Second world war: causes and effects.

8. Economics

National income, Economic indicators - poverty, unemployment, inequality and human development index (HDI). Types of healthcare goods, role of health and education in sectoral composition.

Demography: Population, rural-urban migration and health services, malnourishment and its types and environmental health.

Health governance: role of NITI Ayog, panchayati raj Institutions and urban local bodies in health governance.

Healthcare Infrastructure: health facilities centres, rural health workforce, digital and mobile health infrastructure.

1.1 MEANING OF HEALTH & THEORETICAL DIMENSIONS

1. MEANING OF HEALTH

The word 'Health' comes from the Old English word 'Hale' meaning wholeness, being whole, sound or well. It is one of the most fundamental and complex concepts in social science and medicine.

The meaning of health has evolved significantly over time, from a purely biological understanding (absence of disease) to a comprehensive biopsychosocial and socio-cultural understanding that includes **mental, social, spiritual, and environmental dimensions.**

The way health is defined determines: what gets treated, who gets treated, which policies are made, and how resources are allocated in the health system.

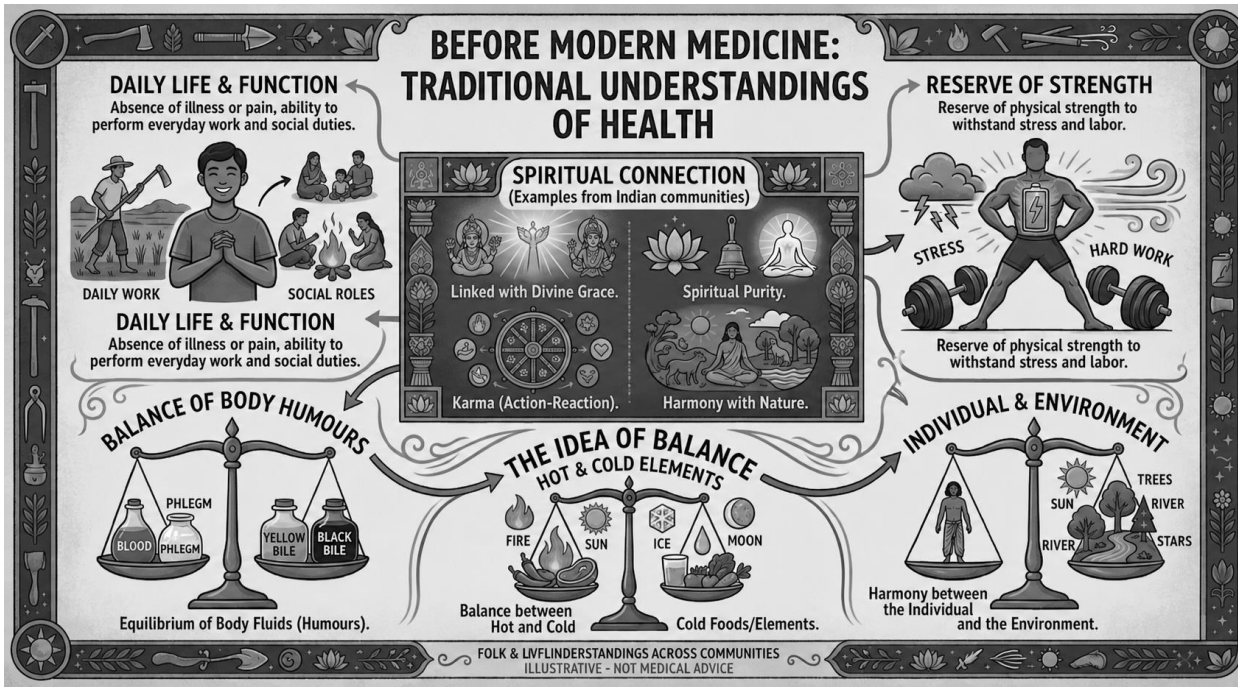
Medical Sociology:

Medical sociology is the study of the effects of social and cultural factors on health and medicine. Around the 1950s, when for the first time the study of doctor-patient relationship was studied as a social system, medical sociology was conceptualized. Medical sociology generally deals with social aspects of health and illness, social role of health establishments and organizations as well as the relationship of healthcare delivery to other social systems and also the social conduct of health personnel and consumers of health.

1.1 Traditional Definitions of Health

Before modern medicine, health was understood mainly through folk or lay definitions that differed across cultures and communities. Generally, health meant the absence of illness or pain and the ability to perform daily work and social roles. Many people also viewed health as a reserve of physical strength that helps an individual withstand stress and hard work. In several Indian communities, health was linked with divine grace, spiritual purity, karma, and harmony with nature.

Another common understanding was the idea of balance, such as balance between body humours, hot and cold foods, or between the individual and the environment.



1.2 Biomedical Definition of Health

The biomedical model emerged in the 17th and 18th centuries with the rise of modern science. It defines health as the normal biological state and views disease as a deviation caused by pathogens, genetic defects, injuries, or physiological malfunction. Influenced by mind-body dualism, it considers illness mainly a physical problem separate from mental and social factors. The model assumes that every disease has a specific identifiable cause, and health can be restored by identifying and eliminating that cause. In this approach, the doctor is regarded as the expert while the patient plays a passive role. Treatment mainly relies on drugs, surgery, and medical technology to repair the biological body.

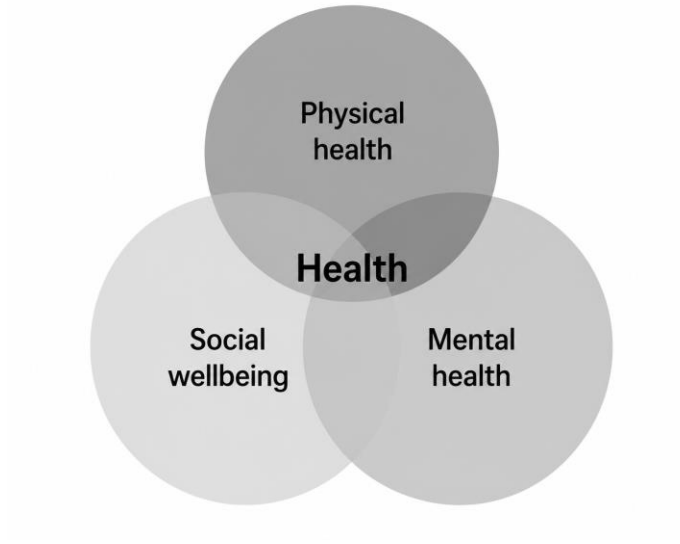
However, the biomedical model has been widely **criticised** for its narrow approach. It **focuses mainly on biological factors** and ignores social determinants such as poverty, inequality, stress, housing, and environmental conditions that strongly influence health. The model also **marginalises psychological and emotional aspects** of suffering by giving limited importance to mental health. Critics argue that it promotes **medicalisation** by turning normal life processes such as childbirth, ageing, and grief into medical problems requiring intervention. It is also considered **reductionist** because it treats the body like a machine and reduces complex human suffering to biological parts, often ignoring the individual as a whole person. Moreover, the model is **culturally limited** as it is rooted in Western scientific traditions and does not fully recognise traditional systems of healing such as Ayurveda, Unani, and Siddha.

1.3 WHO Definition of Health (1948)

"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." - World Health Organization, 1948

It moved the understanding of health beyond the biological/medical framework in three critical ways:

- **Physical well-being:** The proper functioning of the body, absence of disease, adequate nutrition, physical fitness, reproductive health, and freedom from pain and disability.
- **Mental well-being:** the ability to think, feel, and cope with life's challenges. Includes emotional stability, self-esteem, freedom from anxiety and depression, and the ability to enjoy life.
- **Social well-being:** The ability to form meaningful relationships, participate in community life, fulfil social roles, and function effectively in society. This includes freedom from social discrimination and marginalisation.



Significance of the WHO Definition

- **Positive conception:** Health is not just the absence of disease (negative definition) but the presence of well-being (positive definition). This shift opened the door to health promotion beyond disease treatment.
- **Social dimension recognised:** By including 'social well-being', WHO acknowledged that health is not purely biological but shaped by social, economic, and political conditions.
- **Foundation for social medicine:** This definition provided the conceptual basis for social medicine, public health, and the social determinants of health approach.
- **Influenced policy:** It shaped international health policy, leading to declarations like Alma Ata (1978) - Health for All, and Ottawa Charter (1986) - Health Promotion.

Alma-Ata Declaration

The Alma-Ata Declaration was adopted in 1978 at an international conference organized by WHO and UNICEF in Alma-Ata (now Almaty, Kazakhstan). It emphasized "Health for All" through Primary Health Care (PHC), focusing on universal access, community participation, prevention, and equitable healthcare services.

Ottawa Charter

The Ottawa Charter for Health Promotion was adopted in 1986 during the First International Conference on Health

Promotion organized by WHO in Ottawa, Canada. It defined health promotion as the process of enabling people to increase control over and improve their health. The Charter emphasized building healthy public policies, creating supportive environments, strengthening community action, developing personal skills, and reorienting health services toward prevention and well-being.

1.4 Extended and Contemporary Definitions

A. Spiritual Dimension: WHO 1984 Amendment Proposal

In 1984, WHO proposed adding a fourth dimension: spiritual well-being, to the definition, acknowledging that many cultures understand health as inseparable from spiritual balance and religious meaning. While not formally adopted into the core definition, it is widely recognised in health practice globally and is especially relevant in the Indian context where spiritual practices, religious beliefs, and health are deeply intertwined.

B. Biopsychosocial Model - George Engel (1977)

George Engel proposed the biopsychosocial model as a direct challenge to the biomedical model. He argued that health and illness are determined by a complex interaction of three systems:

- **Biological factors:** Genetics, physiology, organ function, pathogens, nutrition - **the body's biology.**
- **Psychological factors:** Thoughts, emotions, beliefs, stress responses, coping mechanisms, personality - **the mind.**
- **Social factors:** Family relationships, social support, economic status, cultural norms, community, environmental conditions - **the social world.**

The biopsychosocial model is now the dominant framework in modern medicine and clinical psychology. It is the conceptual basis for understanding the social determinants of health.

C. Ecological / Environmental Concept of Health

This definition emphasises health as a dynamic equilibrium between the individual and the environment. Health equals successful adaptation to the environment. Disease occurs when there is a breakdown in the person-environment equilibrium.

D. Lalonde Report and Health Field Concept (1974)

Canada's Lalonde Report introduced the 'health field concept' - arguing that health is determined by four main fields:

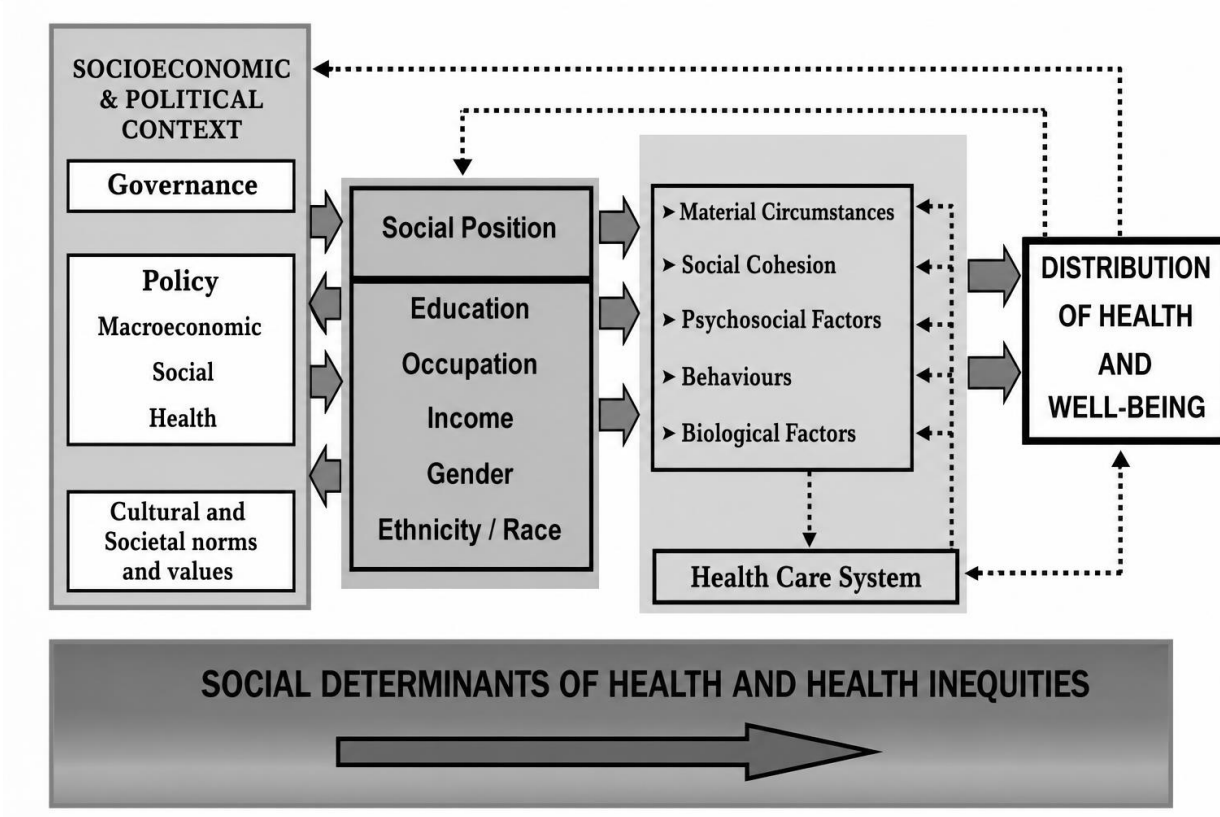
- **Human biology:** Genetic inheritance, ageing, internal body systems.
- **Environment:** Physical environment (air, water, sanitation), social environment (housing, community), and **psycho-social environment** (stress, discrimination).
- **Lifestyle:** Personal behaviours such as diet, physical activity, smoking, alcohol, sexual behaviour, hygiene practices.
- **Health care organisation:** Quality, accessibility, and availability of health services.

The Lalonde Report showed that healthcare (medical services) accounts for only a small fraction of the determinants of health: a finding that challenged the dominance of the medical model and supported investment in public health and social welfare.

1.5 Social Determinants of Health: Marmot Framework

Building on the WHO definition and the biopsychosocial model, Sir Michael Marmot and the WHO Commission on Social Determinants of Health (2008 - 'Closing the Gap in a Generation') established that **health is fundamentally shaped by the conditions in which people are born, grow, work, live, and age:**

- **Income and social protection:** Poverty is the single most powerful determinant of poor health globally.
- **Education:** Education levels correlate strongly with health outcomes, educated people live longer and healthier lives.
- **Unemployment and job insecurity:** Precarious work and unemployment are significant health stressors.
- **Living conditions:** Housing quality, access to clean water, sanitation, and safe environments directly determine health.
- **Early childhood development:** The first five years of life have lifelong effects on physical and mental health.
- **Social inclusion and non-discrimination:** Caste, gender, religion-based discrimination and social exclusion are fundamental causes of health inequalities.
- **Structural determinants:** Governance, economic policies, social norms, and power structures determine the distribution of social determinants across society.



2. THEORETICAL DIMENSIONS OF HEALTH

Sociology of health examines health and illness not just as biological phenomena but as social, cultural, and political phenomena. Three major sociological theoretical traditions have provided distinct frameworks for understanding health, illness, medicine, and healthcare:

- **Functionalism (Structural-Functionalism):** How does health and the medical system maintain social order and functional stability?
- **Conflict Theory (Marxist & Neo-Marxist):** How do power, inequality, and capitalism shape health outcomes and medical institutions?
- **Symbolic Interactionism:** How do individuals construct meanings around health, illness, and doctor-patient interactions?

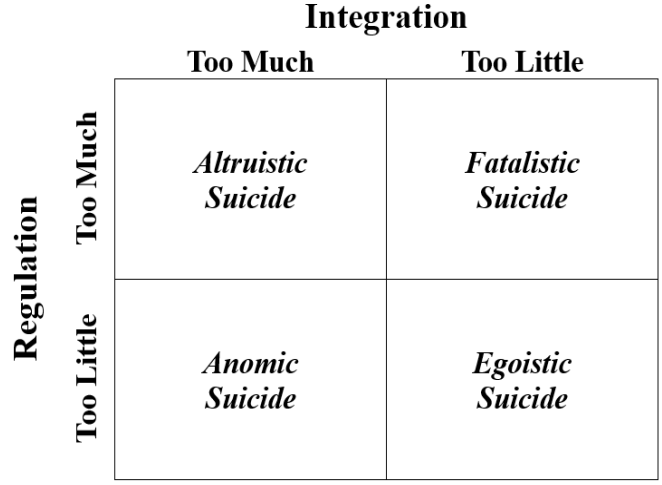
Each perspective focuses on different aspects of health and reaches different conclusions about causes, consequences, and solutions to health problems. Together, they provide a comprehensive sociological understanding of health.

2.1 FUNCTIONALIST (STRUCTURAL-FUNCTIONALIST) PERSPECTIVE

Functionalism, developed by Émile Durkheim and later systematised by Talcott Parsons, Robert Merton, and others, views society as an integrated system of interrelated parts, each of which performs necessary functions that contribute to the overall stability and equilibrium of the social whole. Like a living organism, every part of society - including health, medicine, and illness - serves a purpose.

A. Key Thinkers

- **Emile Durkheim (1858–1917):** Pioneer of sociological analysis of health. His classic study 'Suicide' (1897) demonstrated that even individual acts like suicide have social causes - rates of suicide are shaped by social integration (togetherness) and moral regulation. This was foundational in showing that health outcomes are socially determined.
- **Social integration:** High integration → low suicide (the group protects the individual). Low integration (individualism/anomie) → high suicide.
- **Anomie and health:** Anomie (normlessness, breakdown of social rules) produces psychological distress, substance abuse, and poor health outcomes. This insight is highly relevant to understanding urban health in India.



- **Talcott Parsons (1902–1979):** Provided the most influential functionalist analysis of health through his concept of the 'sick role' (1951). His work in 'The Social System' analysed illness and medicine as parts of the social system that need to function smoothly.
- **Robert Merton:** Distinguished between manifest (intended) and latent (unintended) functions of medical institutions, and contributed the concept of role strain in healthcare.

B. Core Functionalist Assumptions About Health

- **Health is functional for society:** Healthy individuals can perform their social roles - worker, parent, citizen. A healthy population is a productive, stable society. Illness disrupts social functioning.
- **Medicine serves social integration:** The medical profession and healthcare institutions serve the social function of: (a) restoring sick individuals to their productive roles; (b) legitimising genuine illness through diagnosis; (c) controlling deviant behaviour through medicalisation; (d) socialising doctors into professional norms of service.
- **Shared values underlie health norms:** Functionalists believe society shares consensus about the value of health, the authority of medical knowledge, and the obligations of the sick person.
- **Illness as social deviance:** Since illness prevents the fulfilment of social roles, Parsons viewed illness as a form of social deviance - not moral deviance (it is not the person's fault) but functional deviance (it disrupts normal functioning).

C. Talcott Parsons and the Sick Role (1951)

Parsons' concept of the 'sick role' is the single most discussed and examined concept in the sociology of health. It is central to the functionalist perspective and is frequently asked in social science examinations.

What is the Sick Role? Parsons argued that illness is not just a biological condition but a social role - a set of rights (exemptions) and obligations (duties) that society assigns to the ill person. Being 'sick' is a social status with defined expectations, just like being a 'student' or 'employee'.

The sick role has FOUR components - two rights and two obligations:

RIGHT 1 - Exemption from normal social responsibilities: The sick person is temporarily excused from their usual duties - going to work, performing household tasks, fulfilling social obligations. The extent of exemption depends on the severity of the illness. This exemption is legitimate (socially sanctioned), not a moral failing.

RIGHT 2 - Not held responsible for their condition: The sick person is not blamed for being ill. Illness is seen as beyond the individual's control - it happens to them, they did not choose it. This removes moral blame (unlike, for example, the stigma placed on disability or poverty in some societies).

OBLIGATION 1 - Must want to get well: The sick person is expected to genuinely want to recover and return to their normal social role as quickly as possible. Prolonged or enjoyed illness is seen as deviant - 'malingering' (pretending to be sick to avoid duties) violates the sick role.

OBLIGATION 2 - Must seek competent medical help and cooperate: The sick person is obligated to seek out and comply with the advice of medically qualified, technically competent professionals (doctors). Patient compliance is a key functionalist value - the patient trusts the doctor's expertise and follows treatment.

D. The Doctor's Role in Functionalism

Parsons viewed the physician's role as the essential counterpart to the sick role. According to him, doctors are expected to follow four key principles: universalism — treating all patients equally based on medical need, irrespective of their social status, caste, gender, or personal relationship; functional specificity — limiting their authority strictly to the medical domain, exercising control over the patient's health and body but not over other aspects of their life; affective neutrality — maintaining professional detachment and objectivity, avoiding personal emotions, sympathy, or biases in treatment; and collective orientation — prioritising the patient's welfare above personal financial gain, treating medicine as a service profession rather than a business

E. Application to India - Functionalist Lens

- **Caste and the sick role in India:** The sick role is NOT universally applied in India. Access to legitimate sick role status (getting time off, receiving sympathy, accessing quality medical care) varies enormously by caste, class, and gender. Dalits and tribals in rural areas often cannot access the medical infrastructure that would legitimate their sick role.
- **ASHA workers as functional agents:** Accredited Social Health Activists (ASHAs) under NRHM can be understood functionally as community-level agents who integrate the formal health system with local communities, performing the social function of reducing the gap between health norms and health behaviour.
- **Family as health institution:** In functionalist terms, the family in India is a primary health institution - it provides care, nutrition, emotional support, and first-level health decisions for sick members. The extended joint family system is particularly significant in rural UP.
- **Anomie and urban health:** Rapid urbanisation and breakdown of traditional community structures in UP's cities (Lucknow, Kanpur, Agra) produces anomie - isolation, loss of social support - which contributes to rising rates of mental health problems, substance abuse, and chronic disease.

F. Criticism of the Functionalist Perspective on Health

- **Ignore power and inequality:** Functionalism assumes society is based on consensus and shared values, ignoring the fact that health resources, medical knowledge, and sick role access are unequally distributed by class, caste, and gender. It cannot explain health inequalities.
- **Sick role is idealistic:** The sick role assumes patients have equal access to competent medical care. In rural India and UP, lack of doctors, distance from facilities, and cost of care make this a privilege, not a universal reality.
- **Ignores patient experience and agency:** By treating the patient as a passive recipient of expert care, functionalism ignores patients' own interpretations, coping strategies, and resistance to medical authority.
- **Medicalisation critique:** Functionalism tends to support medicalisation uncritically - it does not question whether it is always in society's interest for medicine to expand its domain over more and more aspects of life.
- **Conservative bias:** Functionalism assumes the existing social and medical order is basically functional and good. It cannot explain why the medical system often perpetuates existing inequalities of race, caste, gender, and class.
- **Chronic illness problem:** The sick role was designed for acute illness. For people with chronic conditions (diabetes, TB, HIV/AIDS), the obligation to 'get well quickly' and the exemption from social responsibility cannot apply indefinitely - the model breaks down.

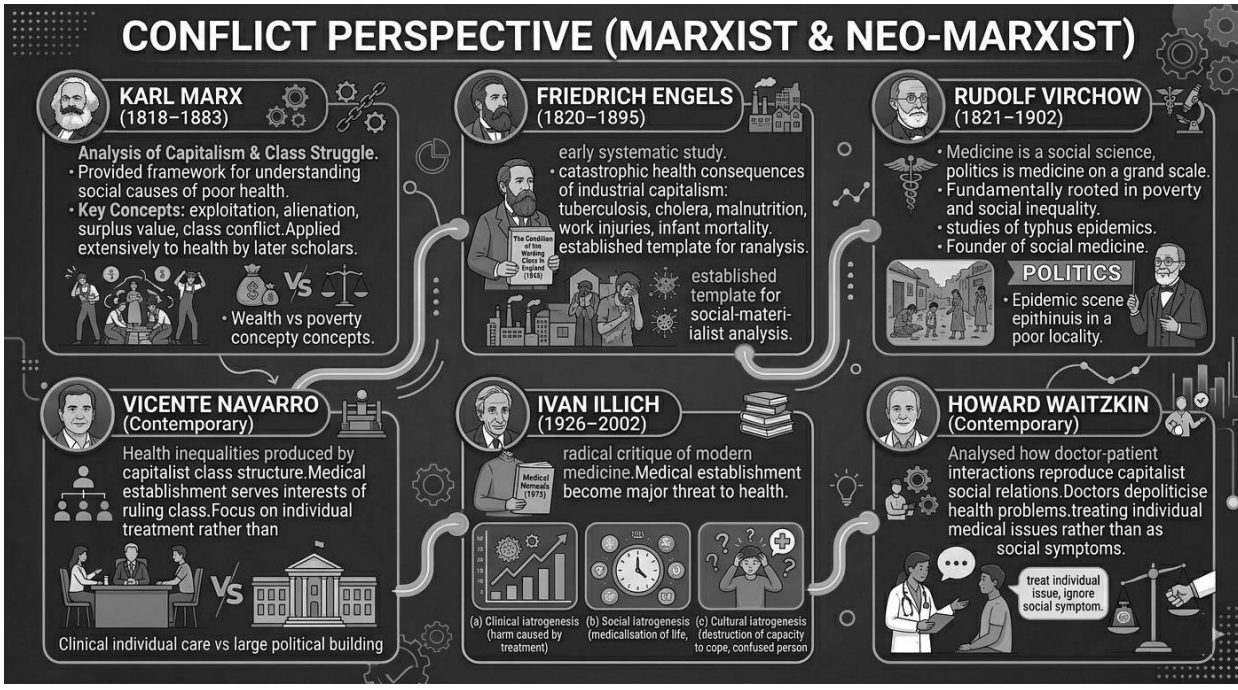
2.2 CONFLICT PERSPECTIVE (MARXIST & NEO-MARXIST)

The conflict perspective, rooted in Karl Marx's analysis of capitalism and class struggle, views society not as a harmonious integrated system but as an arena of conflict between groups with unequal power, competing interests, and differential access to resources. Applied to health, the conflict perspective asks: who benefits and who suffers from the existing health system? How does economic and political power shape health outcomes and medical institutions?

A. Key Thinkers

- **Karl Marx (1818–1883):** While Marx did not write extensively about health specifically, his analysis of capitalism provided the framework for understanding the social causes of poor health among the working class. His key concepts - exploitation, alienation, surplus value, class conflict - have been applied extensively to health by later Marxist scholars.
- **Friedrich Engels (1820–1895):** 'The Condition of the Working Class in England' (1845) - one of the earliest systematic studies of the relationship between capitalism, poverty, working conditions, and ill-health. Engels documented the catastrophic health consequences of industrial capitalism on the urban working class: tuberculosis, cholera, malnutrition, work injuries, infant mortality. This work established the template for the social-materialist analysis of health.

- **Rudolf Virchow (1821–1902):** German physician and politician who argued that 'medicine is a social science, and politics is nothing but medicine on a grand scale.' His studies of typhus epidemics showed that disease was fundamentally rooted in poverty and social inequality. He is considered the founder of social medicine.
- **Vicente Navarro:** Contemporary Marxist health scholar who has argued that health inequalities are produced by the capitalist class structure and that the medical establishment serves the interests of the ruling class by focusing on individual treatment rather than structural/political change.
- **Ivan Illich (1926–2002):** 'Medical Nemesis' (1975) - a radical critique of modern medicine arguing that the medical establishment has become a major threat to health through: (a) clinical iatrogenesis (harm caused by medical treatment); (b) social iatrogenesis (medicalisation of life); (c) cultural iatrogenesis (destruction of people's capacity to cope with illness and death without medical assistance).
- **Howard Waitzkin:** Analysed how doctor-patient interactions reproduce and reinforce capitalist social relations. Doctors tend to depoliticise health problems - treating them as individual medical issues rather than as symptoms of social and political inequality.



B. Core Arguments of the Conflict Perspective

- **Capitalism produces ill-health:** Capitalism creates the material conditions that make people sick: poverty, malnutrition, dangerous working conditions, environmental pollution, overwork, job insecurity, inadequate housing, and stress. The profit motive puts cost-cutting above worker safety and community health.
- **Health inequalities reflect class inequalities:** The most fundamental cause of health inequalities is economic inequality - the rich have longer lives, better nutrition, more access to quality healthcare, and live in healthier environments. These are not natural variations but the products of an unjust social system.
- **Medicine serves ruling class interests:** The medical profession and pharmaceutical industry serve capitalist interests by: (a) treating sick workers just enough to make them productive again; (b) defining health problems as individual rather than social/political; (c) directing research toward profitable treatments rather than preventive social change; (d) maintaining the ideological fiction that individuals are responsible for their own health.
- **Pharmaceutical capitalism:** The global pharmaceutical industry (big pharma) prioritises profits over health. Drugs for lifestyle diseases of the rich receive more R&D investment than drugs for tropical diseases of the poor (neglected tropical diseases). Drug patents keep essential medicines unaffordable for poor countries.
- **Ideology of individualism:** Dominant medical ideology blames individuals for their ill-health ('lifestyle choices', 'unhealthy behaviour') rather than examining the social and economic structures that produce unhealthy lifestyles. This victim-blaming ideology serves ruling class interests by deflecting attention from structural causes.

C. Marxist Analysis of Health in India

- **Class and health:** India's health inequalities map closely onto its class structure. The richest quintile lives an estimated 10–15 years longer than the poorest quintile. The top 20% of households consume 56% of private

healthcare expenditure. Out-of-pocket health spending pushes approximately 63 million Indians into poverty every year (WHO/NHP data).

- **Occupational health hazards:** Workers in India's unorganised sector - construction workers, stone quarry workers (silicosis), textile workers (byssinosis/brown lung), chemical factory workers, agricultural labourers (pesticide poisoning) - face severe occupational health hazards with little legal protection. Their health problems are a direct product of capitalist production processes.
- **Land, poverty and health in UP:** In Uttar Pradesh, the pattern of land ownership (zamindari legacy, landlessness among Dalits and OBCs) is a key structural determinant of health. Landless agricultural labourers in UP have the worst health indicators - highest malnutrition, highest IMR, least access to healthcare.
- **Pharmaceutical industry in India:** While India is the 'pharmacy of the world', producing low-cost generic drugs, the concentration of pharmaceutical production and the patents system mean that drug pricing is still shaped by market rather than health needs. The conflict perspective draws attention to this contradiction.
- **Privatisation of healthcare:** The growth of private hospitals, corporate medical chains, and insurance-based healthcare in India (seen particularly in urban UP) represents the commodification of health - healthcare as a market commodity rather than a public good. This benefits those who can pay while excluding the poor.
- **Caste as a form of structural oppression affecting health:** From a conflict perspective, caste (like class in Marxist analysis) is a system of structural inequality that directly produces poor health among oppressed castes through: occupational hazards (manual scavenging, carcass removal), denial of healthcare (discrimination in public hospitals), malnutrition, and psychological stress of discrimination.

D. Ivan Illich and Medical Nemesis

In his influential book Medical Nemesis (1975), Ivan Illich presented a radical critique of modern medicine, arguing that it has become counter-productive and harmful. He identified three levels of iatrogenesis (medically induced harm): clinical iatrogenesis (direct harm from drugs, infections, surgeries, and unnecessary procedures); social iatrogenesis (creating dependency by medicalising normal life events like birth, ageing, and death, turning people into passive consumers); and cultural iatrogenesis (destroying communities' traditional ability to cope with pain, illness, and death). Illich advocated for demedicalisation and returning health responsibility to individuals and communities. Though criticised for being overly extreme, his work remains a powerful warning against medicalisation and professional dominance.

E. Neo-Marxist and Critical Perspectives

Neo-Marxist views use concepts like Gramsci's hegemony to explain how dominant medical knowledge promotes individualistic, victim-blaming ideas of health that justify inequalities. Feminist political economy highlights how patriarchy and capitalism together harm women's health through unpaid care work. Critical race theory in India examines how caste, class, and gender intersect, resulting in the worst health outcomes for groups like Dalit women agricultural labourers.

F. Conflict Perspective on Health Policy

From a conflict viewpoint, schemes like NRHM (2005) are seen as partial compromises that address health gaps due to political pressure but avoid challenging structural causes such as poverty, caste discrimination, and commodified healthcare. Ayushman Bharat (PM-JAY) provides insurance to the poor but funnels public money to private hospitals, promoting privatisation without tackling root causes. Similarly, widespread malnutrition is viewed as a political-economic issue rooted in land inequality, poverty, and marginalisation of rural and Dalit communities, not merely a technical problem.

G. Criticism of the Conflict Perspective

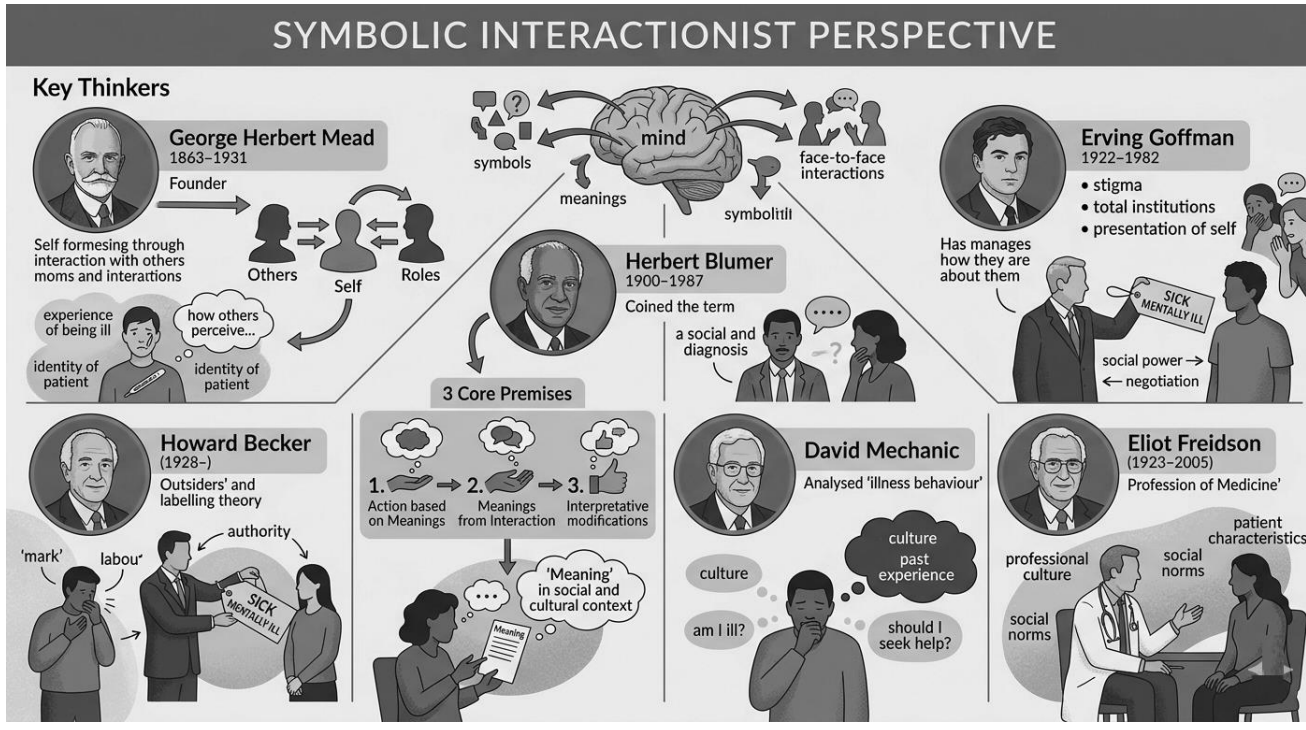
Critics argue that conflict theory is overly economically deterministic, ignoring culture, individual agency, biology, and non-class inequalities. It downplays the genuine benefits of modern medicine (vaccines, antibiotics, surgery). It is also criticised for being too structural, neglecting personal behaviour, subjective experiences of illness, and practical policy solutions within existing systems.

2.3 SYMBOLIC INTERACTIONIST PERSPECTIVE

Symbolic Interactionism, developed by George Herbert Mead and later Herbert Blumer, Erving Goffman, and Howard Becker, focuses on the micro-level of social life - on face-to-face interactions, meanings, symbols, and the processes through which individuals construct their social reality. Unlike functionalism (which looks at society as a whole) or conflict theory (which looks at power structures), symbolic interactionism looks at the everyday lived experience of being healthy, being sick, and navigating the healthcare system.

A. Key Thinkers

- **George Herbert Mead (1863–1931):** Founder of symbolic interactionism. Argued that the 'self' is a social product - we understand ourselves through our interactions with others and through the roles we play. Applied to health: the experience of being ill, the identity of being 'a patient', the stigma of having a particular disease - all are constructed through social interaction.
- **Herbert Blumer (1900–1987):** Coined the term 'symbolic interactionism' and established its three core premises: (1) humans act toward things on the basis of the meanings those things have; (2) meanings arise from social interaction; (3) meanings are modified through interpretation. Applied to health: the meaning of a diagnosis (cancer, HIV, tuberculosis) is not given by biology alone but is socially constructed through interaction, culture, and experience.
- **Erving Goffman (1922–1982):** His concepts of stigma, total institutions, presentation of self, and impression management are among the most influential in the sociology of health. 'Stigma: Notes on the Management of Spoiled Identity' (1963) is foundational for understanding social responses to illness.
- **Howard Becker (1928–):** 'Outsiders' (1963) - developed labelling theory. Applied to health: medical diagnosis is a form of social labelling. Who gets labelled 'sick', 'mentally ill', or 'deviant' reflects social power and negotiation, not just objective biological facts.
- **David Mechanic:** Analysed 'illness behaviour' - the way individuals interpret and respond to symptoms, decide whether they are 'ill', and seek (or don't seek) help. Showed that illness behaviour is shaped by culture, prior experience, social context, and lay beliefs, not just by biomedical facts.
- **Eliot Freidson (1923–2005):** 'Profession of Medicine' (1970) - analysed medical knowledge and the doctor-patient relationship as a social construction. Showed that medical diagnosis is not a purely objective process but is influenced by professional culture, social norms, and the social characteristics of patients.



B. Core Arguments of the Interactionist

PerspectiveThe interactionist perspective views illness and health as socially constructed rather than purely biological. It emphasises how people interpret symptoms, negotiate illness identities, and manage stigma and labelling. Key ideas include the social construction of disease categories, the transformation of self-identity after diagnosis, doctor-patient power imbalances, and the consequences of labelling, which can lead to stigma and self-fulfilling prophecies.

C. Erving Goffman's Stigma TheoryGoffman defined stigma as an attribute that discredits a person, reducing them from a whole individual to a "tainted, discounted" one. He identified three types:

- Abominations of the body (e.g., leprosy, physical deformities),
- Blemishes of individual character (e.g., mental illness, addiction),

- Tribal stigma (e.g., caste, race, ethnicity).

He also distinguished between discredited (visible) and discreditable (concealable) stigma. In India, stigma around leprosy, mental illness, and caste strongly affects social exclusion and healthcare access.

D. Illness Behaviour and Help-Seeking

Interactionists study illness behaviour — how people perceive, evaluate, and respond to symptoms. People first consult family and lay networks before doctors. Cultural norms, gender roles, and caste discrimination influence help-seeking. In India (especially rural UP), women often delay care due to household duties and lack of decision-making power, while Dalits face discrimination in hospitals, reducing their use of public services.

E. Medicalisation

Medicalisation is the process by which non-medical issues are redefined as medical problems requiring professional treatment. It shifts issues from moral or social to medical domains. In India, it is evident in the high rates of medicalised childbirth, unnecessary C-sections, and over-treatment of normal life events. While sometimes beneficial, it expands medical power, creates dependency, and benefits the private healthcare and pharmaceutical industries.

F. Narrative Medicine and Patient Experience

Interactionists focus on patients' explanatory models (Arthur Kleinman) — their personal beliefs about the cause, severity, and appropriate treatment of illness. In rural India, these often include karma, evil eye, hot/cold imbalance, or spiritual causes. When doctors' biomedical explanations clash with patients' cultural models, it leads to miscommunication, poor compliance, and dissatisfaction. Narrative medicine stresses listening to patients' illness stories for better care.

G. Stigma Related to HIV/AIDS, Cancer, and Mental Illness in India

- **HIV/AIDS stigma in India:** HIV/AIDS carries a triple stigma in India: (1) it is associated with 'immoral' sexual behaviour (sex work, homosexuality, extramarital sex); (2) it is associated with drug use (injecting drug users); (3) it is a feared contagious disease. PLHIV (People Living With HIV) face employment discrimination, marital breakdown, social exclusion, and even violence. Stigma leads to: delayed testing, fear of disclosure, non-compliance with ART, and continued spread of infection. NACO's awareness campaigns directly address HIV stigma.
- **Cancer stigma in India:** Cancer is often associated with death, helplessness, and divine punishment in the lay imagination. People often delay seeking diagnosis for fear of getting 'the verdict'. Social stigma: cancer patients may be pitied, feared (through misconception of contagion), or treated as 'already dead'. Women with reproductive cancers (cervical, breast) face added shame due to the association with sexuality. Cancer stigma discourages early screening and delays treatment - contributing to the high proportion of advanced-stage diagnoses in India.
- **Mental illness stigma in India:** Mental illness is among the most stigmatised conditions in India. People with psychiatric conditions are called 'pagal' (mad), seen as dangerous, unpredictable, spiritually afflicted, or permanently damaged. Consequences: families conceal psychiatric illness; patients are taken to faith healers rather than psychiatrists; the mental healthcare system is grossly underfunded (mental health receives <1% of India's health budget); stigma prevents treatment-seeking; patients are often confined, chained, or abandoned. The Mental Healthcare Act 2017 explicitly aims to address stigma and rights violations.

H. Application to UP State Context

- **Lay referral and ASHA workers:** The lay referral system in rural UP means that ASHA workers' community position is critical - they are trusted community members whose health advice carries social authority, unlike distant government doctors. Effective use of ASHAs exploits the interactionist insight that health behaviour is shaped by social relationships and trust.
- **Tuberculosis stigma in UP:** TB is highly prevalent in UP and carries significant social stigma - associated with poverty, poor hygiene, and moral failure. TB patients hide their diagnosis, discontinue treatment to avoid being seen taking pills (perceived stigma), and face marriage problems. The RNTCP (Revised National Tuberculosis Control Programme)/NikShay Poshan Yojana directly addresses this.
- **Gender and illness disclosure:** In UP's patriarchal social structure, women's illness is frequently concealed or minimised. Reproductive health problems (menstrual disorders, maternal morbidity, RTI/STI) are especially undisclosed because of shame and cultural norms around discussing women's bodies. Interactionist analysis helps design culturally sensitive health communication programmes.

I. Criticism of the Interactionist Perspective

- **Ignores structural causes:** By focusing on micro-level interactions and meanings, interactionism can lose sight of the structural economic and political forces that produce health inequalities. Knowing that stigma exists does not explain why certain groups are consistently marginalised in the health system.
- **Too subjective:** The emphasis on meanings and interpretations can make it difficult to develop objective, measurable health indicators and policies.
- **Neglects biology:** In concentrating on the social construction of illness, interactionism can underplay the reality of biological suffering. Some diseases are not 'just' social constructions - they involve real physical pain and disability.
- **Limited policy applicability:** Interactionist insights about stigma and illness behaviour are useful for health communication but do not directly address the need for hospitals, doctors, medicines, and infrastructure.

2.4 COMPARATIVE OVERVIEW OF THE THREE THEORETICAL PERSPECTIVES

Dimension	Functionalism	Conflict Theory	Symbolic Interactionism
Level of Analysis	Macro (society as a whole)	Macro (power structures, class, caste)	Micro (interactions, meanings, identity)
Key Question	How does health system maintain social order?	Who benefits from the health system?	How is illness experienced and constructed?
View of Society	Consensus, integration, shared values	Conflict, inequality, exploitation	Interaction, negotiation, meaning-making
View of Medicine	Functional institution serving society	Ideology serving ruling class interests	Site of power, negotiation, labelling
View of Illness	Social deviance (functional disruption)	Product of capitalism, poverty & inequality	Social construction, stigma, identity change
Key Concept	Sick Role (Parsons)	Class inequality, alienation, iatrogenesis	Stigma, labelling, illness behaviour
Key Thinkers	Parsons, Durkheim, Merton	Marx, Engels, Illich, Navarro, Virchow	Goffman, Becker, Mechanic, Blumer
Strength	Explains norms, institutions, social roles	Explains health inequalities structurally	Explains lived experience, culture, identity
Weakness	Ignores inequality; conservative bias	Over-structural; ignores meaning & agency	Ignores macro structures; policy-limited
India Application	ASHAs, joint family, social cohesion	Caste-health link, poverty, privatisation	HIV stigma, TB disclosure, gender & illness

2.5. Key Sociologists and Their Contributions - Quick Table

Sociologist	Key Work	Key Concept / Contribution
Talcott Parsons	The Social System (1951)	Sick Role - 4 components
Émile Durkheim	Suicide (1897)	Social integration & anomie affecting health
Karl Marx / Engels	Condition of Working Class (1845)	Capitalism produces ill-health; class & health
Rudolf Virchow	Typhus epidemic study (1848)	'Medicine is a social science' - social medicine
Ivan Illich	Medical Nemesis (1975)	Clinical / Social / Cultural Iatrogenesis
Erving Goffman	Stigma (1963)	3 types of stigma; discredited vs discreditable
Howard Becker	Outsiders (1963)	Labelling theory applied to illness
David Mechanic	Various papers (1960s–)	Illness behaviour; lay referral system
Arthur Kleinman	The Illness Narratives (1988)	Explanatory models; illness experience
George Engel	Biopsychosocial Model (1977)	Bio + psycho + social determinants of health
Vicente Navarro	Medicine Under Capitalism (1976)	Neo-Marxist; healthcare serves ruling class
Peter Conrad	Deviance and Medicalization (1980)	Medicalisation of deviance

2.6 CONNECTING THE PERSPECTIVES - INTEGRATED UNDERSTANDING

It is important to demonstrate an integrated understanding - not just describe each perspective in isolation, but show how they complement and critique each other, and how they apply to real health challenges in Uttar Pradesh.

Example: Understanding TB in UP through all three perspectives:

- **Functionalist lens:** TB disrupts the patient's ability to fulfil social roles (work, parenting, community participation). The healthcare system should restore the patient to functional health. ASHAs and DOTS (Directly Observed Treatment Short-course) workers function to integrate sick individuals back into society. The community shares an obligation to support treatment.
- **Conflict lens:** TB disproportionately affects the poor, the malnourished, and those living in overcrowded conditions - it is a disease of poverty and inequality. The government's underfunding of public health infrastructure in UP, the privatisation of diagnostic services, and the social determinants (malnutrition, inadequate housing) that sustain TB are products of structural inequality. The pharmaceutical profits from anti-TB drug development are a conflict-theory concern.
- **Interactionist lens:** TB carries intense social stigma in UP - disclosure leads to social isolation, marital breakdown, loss of employment. Patients' explanatory models may attribute TB to 'chest cold', 'dust', or spiritual causes, delaying biomedical diagnosis. The lay referral system (family, community members) determines whether and when formal healthcare is sought. Doctor-patient interactions may be affected by caste and class biases in public hospitals.

IMPORTANT: In the exam, always connect theory to real Indian/UP examples. Examiners value the ability to move between theoretical concepts and empirical realities of health in India.

If asked to compare two perspectives, always: (1) Define each; (2) State their key argument about health; (3) Give a specific Indian/UP example; (4) Note one strength and one limitation of each; (5) Give a brief integrative comment. This structure guarantees full marks.

RECOMMENDED SOURCES FOR THIS UNIT

- **K. Park:** 'Preventive and Social Medicine' (Banarsidas Bhanot Publishers) - Chapters on concept of health and social medicine.
- **Anthony Giddens:** 'Sociology' (Polity Press) - Chapter on Health, Illness and the Body.
- **Talcott Parsons:** 'The Social System' (1951) - Chapter on illness and the sick role.
- **Erving Goffman:** 'Stigma: Notes on the Management of Spoiled Identity' (1963) - Prentice-Hall.
- **Ivan Illich:** 'Medical Nemesis: The Expropriation of Health' (1975) - Pantheon Books.
- **C.N. Shankar Rao:** 'Introduction to Sociology' - S. Chand Publications - Chapters on health.
- **Ram Ahuja:** 'Social Problems in India' - Rawat Publications.
- **WHO Constitution (1948):** Preamble - definition of health. Available at: who.int
- **NFHS-5 (2019–21):** National Family Health Survey Report - India and Uttar Pradesh. Available at: rchiips.org
- **National Health Policy 2017:** Ministry of Health and Family Welfare, Government of India. Available at: mohfw.gov.in