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Review Paper

Revisiting Social Determinants of Health in the Era of COVID 19

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Abstract

Health inequalities is a complex concept marked with relative health disadvantages experienced by one section of population over the relative health advantages experienced by other section of the population. Over the few decades there is seen an improvement in health status in most of the countries. But within the context of existing and rising inequalities in health. The World Health Organization (WHO) Commission of Social Determinants of Health (CSDH), 2008 reinvigorated the issue of health inequalities and its structural causes within global public health context. But it was not until COVID19 pandemic that health inequalities became the center of public health discussions again. The social determinants of health (SDH) concept and discourse flows from debates of inequalities in health and in health status. The purpose of this paper is to discuss the concepts of SDH within which agenda of CSDH is recommended. The paper explains the intrinsic values on which the concept of SDH is build, the meaning of SDH, and historical and political context which resulted in formulation and publication of CSDH 2008 report. The paper end with analysis on similarities and differences between primary health care and social determinants of health approaches. The CSDH report is considered as revival of the Alma Atta declaration, 1978 primary health care (PHC) approach.

Keywords: Health Inequalities; Social Determinants of Health (SDH), Primary Health Care (PHC), COVID-19

Introduction

Over the past few decades there has been improvement in health status in most of the countries in the world. But within the same period inequalities in health between individuals, socio-economic groups, countries, regions and within countries has increased. Inequalities in health are critical and persistence discourse in public health discipline and research. Health inequalities are complex concept which explains relative health disadvantages experienced by a section of people/groups compared to relative health advantageousness experienced by the other section of people/groups. These relative health disadvantages explain the differential in risks of exposure; differential in risks of infection; differential in risks of diseases development; and differential health outcomes among individuals and socio-economic groups. There is a paradox in health where there is persistent health inequality despite remarkable achievement in health outcomes in most of the countries. This paradox shows that health cannot be measured in objective terms of health indicators or health outcomes. But involves complex changing social-cultural, economic, and political processes influencing the health of the individuals and populations. Inequalities in health have persisted for many decades. But it became even more apparent during the recent public health emergency of COVID-19 pandemic. The pandemic clearly showed that the COVID-19 discriminates against individuals, ethnic and minority groups and communities marked with socioeconomic differences and vulnerablities[1-4].

Social determinants of health (SDH) concept and discourse flows from the debate of inequalities in health and in health status. Social determinants of health provide an explanation of the paradox in health and focuses on exploring the root causes of health inequalities. It also identifies possible interventions points for addressing them in public health policies and programs.

Social determinants of health discourse critique the limits of modern medicine rein forming the role of socio-cultural, economic and political dimensions of population health. The history of public health shows that SDH is not a new idea in public health. But SDH idea was never able to establish itself in the political and health policy making discourses of the public health history.

World Health Organization (WHO) Commission on Social Determinants of Health (CSDH), 2008 reinvigorated the issue of health inequalities and its structural causes within global public health discourse. Commission report provided a major shift in health policy discourse at global level from completely medical understanding of diseases to looking at social dimension of diseases. The report has stimulated the debates and research literature on understanding SDH and investigating possible intervention points for addressing them in public health policies and programs.

Despite CSDH report inequalities in health until the outbreak of COVID19 largely were not the core of the discussion on public

health policies and health interventions. The present research paper is conceptualized within the context of rising health inequalities and momentum provided by COVID19 to SDH discourse within public health discourse. The purpose of this paper is to discuss concept of SDH within which agenda of SDH is recommended by CSDH 2008 report. The paper explains the intrinsic values on which the concept of SDH is build, the meaning of SDH and the historical and political context which resulted in formulation and publication of CSDH 2008 report. Commission report is considered as the revival of Alma Atta declaration, 1978 Primary Health Care (PHC) approach. The paper end with analysis on similarities and differences between PHC approach and SDH approach.

Intrinsic Values to Social Determinants of Health

Commission on social determinants of health has again put forth the global agenda of social justice in public health discourse which was largely undermined with exclusive focus on biomedical selective health interventions largely promoted by dominating class vested interests. Achieving social justice by addressing SDH is a prerequisite within the context where health inequalities are killing people and differences in health status within and between countries are growing. It is an urgent priority not only for low-and middle-income countries. But also, for the whole society to restructure the society for equitable healthy environment where every individual has access to resources to maintain a healthy life.

World Health Organization constitution place health within the social context with its broad and holistic health definition – 'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity[5]. Health is a human right and people have right to access resources without discrimination which enable them to enjoy health of attainable standard[5]. Health is conceptualized by WHO within social justice framework in which each individual has right to access resources to maintain healthy living standards and thereby a healthy life.

The intrinsic values on which CSDH health equity agenda is based on are – social justice, participation and inter-sectoral action. The CSDH report has given a global call for global partnership for achieving health equity in health status[6].

Social justice is the essential value under which the agenda of health equity is placed. Rawls theory of justice defines justice as fair distribution of primary goods on the basis of 'fair equality of opportunity' to individuals in disadvantage position because of natural selection or social selection of life[7].

Justice is essential to reduce social inequalities determining unequal distribution of social and economic resources. Thus, social justice is redistribution of resources of society in equitable manner. Redistribution of resources is essential to achieve justice in the context, where there are significant majority of citizens at relative social and health disadvantageous position compared to significant minority of citizens at advantageous position because of more accumulation of resources and powers[7].

Redistribution of resources calls for equity in distribution of society resources and services through restructuring of society on egalitarian principles. Along with participation of privileged classes who are unwilling to go off their accumulated resources. Thus, social justice is a collected effort of society than individuals. It ensures that every individual is entitled to get resources to meet their basic needs[7].

More broad definition of social justice is provided by capability theory of Professor Amartya Sen. Capability theory goes beyond accessing primary goods theory of justice or redistribution of resources in more equitable manner to gaining individuals capability to function[8].

Capability approach states that human life comprises of set of 'doings and beings' together they are called as functioning. It is the capability to function to live a quality life than mere access to resources. Availability of resources will not give individuals opportunity to build sufficient capabilities to function. Social policies are means to removing obstacles which come in the way of functioning of individuals. Capability approach calls for freedom of individuals by expanding human capability to live a kind of life which individuals want or desires[8].

Within the public health discourse, the SDH approach gives emphasis to expanding capability of people or freedom of people to achieve and live a healthy life. It calls for broader and multi-sectoral approach to policy making to address the range of health-related areas beyond the health sector which influence the health of people. It also calls to look beyond the compartmentalized and hierarchical structures of government to make polices more effective in improving population health.

Thus, capability approach takes a broad perspective on determinants of health. It gives emphasis to the role of health polices to extend the freedom or opportunities for individuals and communities to achieve capability. Capability to function of individuals and population to live a healthy life.

Social determinants of health are based on the value of 'Universalism'. Universalism notion of values are based on the principle of providing accessible public services to the whole population without any loss of human dignity or self-respect. Universalism is based on the argument that public social services should be provided for everyone without any selection criteria. If services are not provided for everyone it would not be available at all. Accessibility of services will depend on purchasing power or will only be available to a section of population. This will create stigma and inferiority among people receiving services. Universalism is essential for effective utilization of services in countries with highly unequal

environment and social services are to be provided by state to all without affecting the dignity of users[9].

Opposite to universalism is the notion of selection which considers welfare as burden and waste of resources by providing to all people who might not need. To avoid waste of resources only solution is to provide services only to those people who are deprived of resources and in need of it. This approach restricts provision of social services to only minority population based on selection criteria while rest of advantageous population are required to pay to purchase public services[9].

Social determinants of health are based on intrinsic values of social justice, equity in redistribution of resources and services, and universalism. These are fundamental values to population health. But dominant value in current free market economy is selection of services. Based on the principles of selection packages of health services are provided to minority of population and rest of services are purchased in the market. Such health services are affordable to only those with the power to purchase based on socio-economic position in the society. This further contribute to social inequality in access and affordability to health services in the society.

What are Social Determinants of Health?

Health is a complex phenomenon determined not only by biological factors. But social-cultural, economic, political psychosocial and environmental factors. The dominant biomedical understanding considers only the biological factors as determinant of health. But recent national and international debates under the framework of social justice on health inequalities in health within and across social groups and countries has reinforced the importance of looking at the social and biological factors as an integrated concept. The debates also emphasize on the policy interventions to curtail social inequalities in health through actions on population level SDH. Such policy action requires inter-sectorality in action because of the complexity of health and its inequalities. So, to develop policy for health interventions it is essential to first conceptually define the term 'social determinants of health' and identify the range of factors which produce social inequalities in health.

The SDH concept grew out of the literature of 1970s and early 1980s critiquing the limited perspective of modern medicine focused on individual level risk factors of diseases. Central to this critic was that medical care was not the main driver of the people's health and there were increasing health inequalities[10-13].

The researchers of this period tried to understand and explain the specific mechanisms through which different socio-economic groups member's experience differential exposures to pathogenic agents, differential susceptibility to develop diseases and differential health outcomes.

Two milestone investigations which highlighted the health disparities and SDH were Black report commissioned in 1977 and White Hall study of 1960. Both the reports investigated the socio-economic inequalities in health status and incidence of diseases in population. The Black report provided evidence on social conditions shaping health inequalities and recommended for interventions in non-medical sectors such as education, housing, and social welfare[12].

In the Black report one of the main highlights was the recommendation on preventing inequalities in health through focus on early childhood years. The White Hall study of comparative health outcomes among British civil servants provided evidence on social gradient in health among different levels of employees with increased risk of chronic diseases mortality more among the lower classes than among the rich classes[14,15].

Both the reports put forth strongly the agenda of health inequalities at global forum and generated a series of debates among and within countries on relooking at the population health and its determinants.

Social determinants of health are shaped by both non-medical and non-behavioural factors. Determinants of health require an interdisciplinary approach for investigating consisting of epidemiological, sociological, political economy and human rights approaches to understand health determinants, inequalities in health status and for promoting health of population. It includes biomedical, behavioural, environment, social-cultural, political, economic risk factors at individual and population level. It also encompasses structural level socio-cultural, economic and political factors defined as *causes of causes* of population health which influences the individual and community level risk factors. It goes beyond biomedical and behvaioural risk factors framework of understanding diseases and its distribution among social groups towards a more holistic health prevention and promotion approach[6].

There are a range of factors which encompasses SDH documented by different research studies so it is difficult to decide a set of factors only which could be called as social determinants of health. Marmot and Wilkinson takes early life; food; labour market; neighbourhood environment; housing conditions; psychosocial environment; stress; social exclusion; ethnic status; poverty; transport; health in older age; sexual behaviour; social support and cohesion factors as SDH[15].

Social determinants of health concept include understanding of health determinants beyond health care services expanding it to structural and individual level health determinants. It includes social conditions in which people live and work; and structural factors which shape such social conditions. Thus, all forms of social, economic, political deprivations and basic necessities are essential for health of population.

Social determinants of health approach to public health and social polices planning and program implementation is again put forth on the global agenda by the WHO CSDH report, 2008. The report is written within the context of the rising health inequity with varying health status within and across countries. Commission report takes a holistic definition of SDH and health inequity focusing on the concept of social gradient in health of the poor; social gradient in health within countries and across countries; and argues that there is no biological reason for health inequalities. But such inequalities are shaped by larger structural factors. Commission acknowledges the fact that health improvements have been made over the years. But does not explicitly state on the degree of SDH or bio medical measure's role in improving the population health. Commission report is based on the principal of social justice, participation, and inter-sectoral actions calling for global partnership for achieving health equity in health status[6].

The report acknowledges the fact that SDH is not a new knowledge in the field of public health. But appropriate evidence-based knowledge for policy making and action on SDH is required to reduce health inequalities. Social justice and knowledge for action are the key concerns in WHO CSDH report. The new approach to development put forth in the CSDH report is health in all social and economic policies. It calls for convergence of other non-health sectors with health sectors. So, as to address the SDH and promote health equity based on the evidence that many of the non-health sector interventions have significant health impacts[6].

The report has stimulated the debates and literature on understanding factors which act as SDH and result in social inequalities in health. It calls for action to look for intervention points for addressing SDH in public health policies.

Historical and Political Context of Social Determinants of Health

The historical roots of penetration of social in biomedical understanding of health needs is to be understood from the political context which provided the evidence and support for SDH understanding in health and health inequalities. World Health Organization constitution clearly reflected the ideology for support of social and economic forces in shaping health. It acknowledges the influence of social and political conditions on health and need for inter-sectoral approach with other non-health sectors[5].

The health sector during the period of 1950s and 1960s was dominated by technology driven 'vertical' disease control health programs without any concern for social contexts within which diseases are shaped. The emergence of Soviet Union as the world power paved the way for Alma Atta Declaration in 1978. The declaration called for global commitment to the goal of 'Health for All' by the year 2000' and promoted primary health care (PHC) approach. This goal emphasizes the importance of social conditions as determinants in shaping the health of individuals and populations. It recommended inter-sectoral approach in health planning and implementation[17,13].

The 'Health for All' movement rejuvenated the comprehensive approach for understanding and incorporating SDH in health policy making of many countries. But end of cold war and subsequent collapses of Soviet Union marked the retrieval of health equity agenda and comprehensive PHC approach. The collapse of Soviet Union had population level health consequences in its constituent countries with major changes in mortality pattern and rapid decline in life expectancy at birth[18]. The PHC approach was replaced by selective PHC and later on by neoliberal polices. This reversed the process of SDH with a focus on cut backs in social welfare schemes. It introduces market-oriented reforms focusing on efficiency over equity as a goal for health sector. Neoliberal polices reduced the quality of many SDH and increased the health disparities among and within populations[13,16].

By late 1990s and early 2000s as a consequence of growing health disparities there was growing of evidence on failure of health polices in reducing health inequalities. This started an initiative all over the world primarily in Europe and other developed countries to mainstream the health equity and social determinants of health in health policies and programs through inter-sectoral approach[13,16].

The global and institutional commitment for Commission on Social Determinants of Health (CSDH) was made with a change in WHO's director-general position in 2003. Doctor Lee Jong-wook with strong health equity ideologies, after taking the WHO's director-general position announced for setting up of CSDH. The CSDH fundamental purpose was to gather the existing knowledge on SDH and translate it into policy interventions in low-and middle- income countries where health disparities are prevalent. The CSDH report published in 2008 marked the revival of WHO constitutional mandate and Alma Atta 'Health for All' values towards health equity and social justice[13,16].

Commission on Social Determinants of Health (CSDH), 2008 and Alma Atta Declaration, 1978 – *Similarities and Differences*

Health equity agenda of CSDH report is not the first time put forward on the global forum by the World Health Organization. World Health Organization constitution, 1947 and landmark Alma Atta declaration of 1978 had similar goals to achieve global health equity.

Commission on social determinants of health report is considered as a revival of Alma Atta declaration 1978 and there are comparisons being made between both the documents. Alma Atta declaration PHC approach and CSDH report SDH approach are seen as same but with essential differences[6,19,20,21].

Such comparisons are essential to look within the context of CSDH report which marked the 25th anniversary of Alma Atta declaration, 1978. There is also a global momentum for revival of PHC approach to address the current complex global health challenges. Epidemiological, demographic, socio-cultural, political, economic and environmental changes in global health are creating new global health risks which require new strategies to resolve such challenges[20,22,23].

Ideologies and Values: Both the CSDH and Alma Atta documents were outlines within the socialist ideological framework. Looking for the causes of ill health beyond the health sector at the structural levels and demanding for redistribution of resources. Putting health within the human rights framework and not only as a means of economic development. The PHC approach upholds the values of universality, equity, and social justice. While SDH approach is based on the principals of social justice, participation, and inter-sectoral approach. It is not only the health ideologies formed by epistemic communities and thereby political actions which both the documents' stresses. But also, answered the essential question on how to address and improve the health of people within the context of growing curative health care services and rising inequalities in health[6,10].

Context: Both the CSDH and Alma Atta documents are placed within the context of end of World War II, rise of global capitalism, and increases in social and health inequalities.

Alma Atta declaration was an outcome of long struggle by Soviet Union and WHO to put forth the agenda of health services development[19].

Alma Atta declaration, 1978 was conceptualized within the backdrop of end of colonial rule; setting up of democratic government in independent colonies; rising aspirations of people in liberated colonies; cold war tensions; non-aligned movement; and focus on vertical health programs of 1950s and 1960s promoted by United States (US) which neglected development of integrated health services[6,17,19,24].

The ideological and political tensions between the two powers of the world in the period of cold war. The widespread discontent among the people towards health services. Resulted in abandoning of vertical health programs and called for basic health services development under the Alma Atta Declaration. It was a collaborated effort by WHO and UNICEF (United Nations International Children Education Fund). There was a shift in the understanding that present health crisis is not only because of the organization of health care delivery system. But also due to the broader socio-economic and political structure of the world which gave rise to disparities in health.

Commission on social determinants of health is conceptualized in the period of end of cold war; collapse of Soviet Union and its socialism ideologies in the world; rise of selective PHC in the form of selective package of health services; period of 1980s and 1990s shaped by cuts backs in subsides to social welfare schemes under the neoliberal agenda and structural adjustment program; declining role of states; privatization and commodification of health services based on market principles; and high levels of social and health inequalities[19].

Rise of Bretton Wood institutions and decline in global health leadership resulted in health priorities decided more by World Bank and its allied funders constituting of multilateral agencies and rich countries donors. Period of 1990s also saw scientific advances in understanding of SDH, implementation of SDH polices by Europe, Canada and other developed countries to reduce inequalities and to improve population health. Period of 2000 build the momentum to recognize and address social dimension of health. The Millennium Development Goals in 2000 were adopted by 189 countries which promoted the targets for social as well as health improvement for achieving social development through a multi-sectoral approach. At the same time there was a strong and sustained pressure by the people's health movement on WHO to put the agenda of SDH at the global forum[23].

So, the voices and demand for addressing SDH have come from below reflecting the discontent among the section of people towards health services and injustice by society in general.

Commonalities and Differences: The fundamental commonality between both the CSDH and Alma Atta document is that both focuses on the increasing health inequalities within and across countries. Both the documents draw the world's attention to an often-overlooked state that health inequalities are killing people and is socially unacceptable within the current political, economic, social context. For improving health and achieving the goal of global health equity Alma Atta uses the tool of PHC, whereas CSDH report demands for action on SDH caused by structural factors. So PHC and SDH are the two paradigms taken by the both reports to achieve the goal of 'Health for All'. It would be irrelevant to see both the documents as separate as the agenda of PHC encompasses action on SDH and PHC could not be achieved without addressing SDH[6,10,21].

Primary health care (PHC) approach is a process to provide continued comprehensive primary health level of care (includes promotive, preventive, curative and rehabilitative care). It is the first level of contact for an individual, family and community with the health service system which is linked to integrated referral health service systems. It is an approach which calls for development of health services based on people's need[10].

Social determinants of health (SDH) approach are determined by factors shaped by places in which people are born, live, work, and grow and systems put in place to deal with illnesses. The SDH is determined by political, social, and economic forces

which impact the health and needed to be addressed for achieving health equity. The CSDH document aims to improve daily living conditions; tackle the inequitable distribution of power, money, and resources; and measures, understand the problem, and assess the impact of actions[6].

So, the differences in both approaches are only in the lens which both the documents use to address health inequalities through inter-sectoral action. Primary health care (PHC) approach starts with building integrated health system at the community level and then move on to addressing the environmental, social-cultural, economic, and political factors which impact population health. So, it is the health system which needs to be build first and then actions at population level health determinants. Social determinants of health (SDH) take a reverse approach by addressing causes of the causes (environmental, social-cultural, economic, and political factors) at the population level and taking health system as one of the determinants of health among other determinants. Social determinants of health address the risk factors which increases the risk of exposure, risk of vulnerability to diseases, constraints in accessing health services, and result in differential health outcomes.

Alma Atta declaration does not mention the term 'poverty' which is an important social determinant of health and its inter-sectoral action is limited to basic level with improvements in environment, sanitation, nutrition, housing and others[10,24].

The CSDH inter-sectoral action is much broader as it not only recommends for improvement in daily living conditions. But also focusses on re-structuring of the society through equal distribution of resources, power and money[6].

Central focus of both the documents is organization of health system; inter-sectoral action; community participation for people central approach in health planning and implementation; appropriate use of resources and technology; emphasis on state intervention to promote health equity; demand for new global social and economic order for development; and call for coordinated effort by the whole of society in the form of a global movement to achieve the goal of global health equity[6,10]. The CSDH promote the agenda of considering health in all policy and sectors, and called for equal distribution of power, resources, and money. Thus, both the approaches take a more holistic definition of health and health actions to increase population ability to live a healthy life by considering the health determinants beyond the health system.

There is critic on drawing comparison between SDH and PHC approaches which can be counterproductive. As both the approaches common concern is to address the factors which are beyond the health sector. Doubts are raised on the approach of PHC as a broad principal to derive action beyond health sector. Within the context where there is an increased focus on curative health services and demand to revitalize PHC by providing health services based on the principals of PHC. Policy makers can get and excuse on not addressing factors beyond health services system which are SDH focused as it would be considered a broader objective for the entire health sector[21].

The CSDH report is being criticized to be historical and political. As it fails to learn from the past and factors which stood in the way of implementation of health equity agenda. It fails to take into account the political forces and ideologies of the two poles in the cold war period and the role of WHO leadership which resulted in the international conference on Alma Atta[24].

It fails to learn the reasons for retreat from PHC to vertical approach under selective PHC undermining the role of social dimensions of health. Selective PHC constitutes technocratic, cost effective, diseases specific care promoted by WHO and UNICEF in form of GOBIFFF (Growth Monitoring, Oral Rehydration Techniques, Breast Feeding, Immunization, Food Supplementation, Female Literacy and Family Planning). It fails to learn from failures of Commission on Macroeconomics and Health, and from Millennium Development Goals[17,19].

It fails to learn from experiences of socialist countries such as former Soviet Union, the Warsaw Pact countries, China, and Cuba in successfully implementing integrated health services with a focus on SDH approach[19].

It fails to understand the current context in which WHO work, under the influences of dominant alliance of rich countries and rich of poor countries which shapes the health polices against WHO constitutional mandates[25].

It is important to look at the common historical experiences of both the documents. But it is more important to look at the political tensions and ideological values which shape the documents. Rather than only focusing on the implementation agenda of SDH. It was changes in leadership of WHO and thereby ideologies which made the ground for placing health equity agenda at global level. The changes in WHO reinforced broad population health approaches at global and national level such as PHC and SDH. So as to improve population health within and across socio-economic groups and countries.

The CSDH report emphasis on architectural correction in socio-economic structure of the society to achieve goal of equity in health. The report is a revival of 'Health for All' agenda of Alma Atta, 1978. But it misses to take into account the political and economic historical context which leads to Alma Atta failure. The PHC and SDH are not two separate approaches. But they are complementary to each other for improving the health of people and decreasing inequalities in health.

Conclusion

Social determinants of health are based on intrinsic values of social justice; equity in redistribution of resources and services;

universalism which are fundamental to public health. But in the current neoliberal global context where there is dominance of 'Health Economics' and 'Medicine' disciplines in formulating public health polices these intrinsic values of SDH are not focused in health policy making process. This dominance of health economies and biomedicine in global health policy making is based on the value of free market economy which reduces the role of the state in social and health welfare schemes formulation and implementation.

The dominance of health economics overs the disciplines of social sciences has made health as only means of economic development and not a human right. This has given rise to 'selectivity' in health interventions and investment in health through cost effective packages of health services. Such packages of health services have made a clear distinction between clinical and public health services. This has undermined the population level comprehensive approach to addressing the population health determinants through public health interventions.

These packages of health services promoted by health financing reports are supported more by donors as they ensure return on investment with measurable time bound outputs and outcomes. There is a dominance of market in promoting such packages of health services as it creates space within the health services provisioning and financing.

Health priorities decided based on selective packages of health services are provided only to minority of the population and rest of the population purchase health services in the market. Market creates more commodification of health services and disparities in accessing curative health care services. As expensive curative health services are affordable only to those section of population with purchasing power. This creates inequality in access and affordability of health services across and within socio economic groups and countries.

In the current global context capitalism is dominant not only in economic growth. But even in reducing the role of state on social welfare agenda setting. It decided social investment polices based on its market principals to bring profit to market growth and capitalists. Capitalism in health is dominant in prioritizing health services for population with selectivity in health interventions based on its economic arguments.

This has resulted in decline in global leadership of WHO which is now promoting the agenda of financing institutions and rich countries' donor agencies which are currently dominant in financing most of the population health programs.

The health interventions promoted by market are not based on values of community participation. It does not focus on designing of health policies and its implementation through people's centered approach. Market promotes health interventions which over medicalizes health problems and are completely technological fixes to health problems.

This undermines the value of appropriate use of resources and technology promoted by Alma Atta primary health care approach. It also undermines the value of addressing social determinants of health to reduce inequalities in health. So, to address the goal of global health equity it is essential to look for feasibility of investment in comprehensive model of SDH. Over the investment in health needs promoted by global health financing institutions and donor agencies.

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