
# The social causes of disease

Health and illness are not strictly random or natural states of affairs. They do not depend solely on biological issues,  the environment, individual behavioural factors or medical treatment. The distribution of disease is almost always a function of one's socio-professional status or social class. As a rule, those at the top of the social pyramid enjoy better health than those directly below them, who are themselves in better health than those just below them … and so on down the pyramid. In other words, the higher you go up the social hierarchy, the better your health. This is what is commonly known as the social gradient in health. The reality (described above) covered by this term can be identified both within countries and internationally.

## From social inequalities to health vulnerabilities

What follows is an attempt to demonstrate that social inequalities reinforce health vulnerabilities, prolong pandemics and fuel inequalities in the length and quality of life on an international scale. This was clearly demonstrated by the COVID-19 pandemic.

> COVID-19 has “disproportionately affected hundreds of millions of people among the most disadvantaged po
> such as those living in low- and middle-income countries, those belonging to socially discriminated groups ar
> informal employment, as well as girls and women”. Above all, we are “reminded of a harsh reality: unequal a
> income and opportunities is not only a source of unjust, dysfunctional and unhappy societies, it literally kills p
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> Jayati Ghosh (2022), “Forewords”: in Inequality Kills, Oxfam Briefing Paper, January 2022, p. 4.

The same is true of HIV, TB and malaria. Here too, the social gradient in health has a significant explanatory power. Diseases are more prevalent at the bottom of the social ladder and diminish the higher up the ladder you go. In the opinion of the two Executive Directors of both the Global Fund and UNAIDS, “ in the fight to put an end to disease, inequality is often the main obstacle”. Inequalities aggravate pandemics and feed on them (bidirectional causation). They uncover gaps in our societies and exacerbate them. In short, they make diseases and pandemics longer-lasting, more deadly and more damaging for developing countries, including many African countries which, incidentally, bear the heaviest burden of certain diseases.

While it is true that research into and access to antiretroviral drugs (ARVs) has increased the life expectancy of people living with HIV worldwide, it is still close to the average for each country. For example, while the life expectancy of a man living with HIV and on treatment is 53 years and is 54.2 years for an HIV-negative person born in 2019 in Chad, it is 69.4 years for someone on treatment and 82 years for an HIV-negative person born in 2019 in Canada. The 16- and 28-year gap between the two categories in the countries cited cannot be attributed solely to the natural lottery of life or to religious determinism of the “it was his day” type (understood here as: the day on which he was bound to die).

While it is true that other factors (gender, age, biological make-up, skin colour, disability, etc.) play a part in the distribution of health vulnerabilities, it can nonetheless be said that socio-economic factors (income inequalities, social insecurity, inadequate state resources, a weak health system, etc.) account for the low age that Chadians living with HIV can expect to reach compared with Canadians.

On an international scale, there is generally a factual, empirical correlation between income or gross domestic product (GDP) levels and vulnerability to disease and pandemics. Living standards subordinate, determine and structure these vulnerabilities in a central and decisive way. Having a higher social status, a more stable job, being richer and better educated not only guarantees a better social situation, greater financial ease and more favourable living conditions, it also leads to a longer and healthier life. In fact, as Didier Fassin points out, there is a major difference between life expectancy in terms of duration and life expectancy in terms of quality of life.

> “On the one hand, how many years can we expect to live? On the other, what can we expect from life? Movi
> the first to the second formulation radically shifts the perspective. Talking about the inequality if life is no long
> question of disparities in the length of life, but of the differences between wat life is and what individuals are e
> expect from it. We are no longer talking about quantity, but about quality, no longer about longevity, but abou
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> Didier Fassin, L’inégalité des vies, inaugural lecture delivered at the Collège de France on Thursday 16 Jan

Global inequalities kill in Africa

On analysis, it is clear that it is domestic and, above all, international economic structures that generate these profound inequalities. The effects are particularly glaring in sub-Saharan Africa. The health insecurity – and hence the inequality of life – that is the daily lot of the continent is first and foremost due to the growing scale of global inequalities.

Let’s take another example to illustrate our point. A Kenyan woman had been suffering from the following symptoms for several weeks: physical discomfort, progressive weight loss, fever, prolonged cough, swollen lymph nodes, loss of appetite, shortness of breath and chest pain. She went to hospital, where medical examinations revealed that she had TB. Despite medical treatment, she died a few days later. At first reading, in this case medical, the example speaks of a complication linked to the late detection of the active form of the disease. But there are other (complementary) ways of elucidating the causes of her death. A broader analysis would reveal that if this cleaning lady (her profession), widow and mother of five children had presented late at the hospital, it was because she had problems accessing care (costs, distance, insurance, etc.). Worse still, she lived in insalubrious accommodation in a poor, polluted neighbourhood that is extremely conducive to the outbreak of infectious diseases. In fact, for this woman, as for many other residents of her neighbourhood, the precariousness of her social or biographical life ended up leaving its deadly mark on her biological life. Borrowing once again from the words of the health anthropologist Didier Fassin, we can say that here, as in many similar social circumstances, death corresponds to the ‘writing’ on one’s physical body of the inequalities produced by society. It is, so to speak, the culmination of the process by which the social aspects of life get under the skin.

However, while it is true that inequalities kill, the solutions are within our reach. The fight against HIV, TB and malaria is fundamentally a question of social justice. Despite the scale and complexity of the task, it is the social levers that must be brought to bear if we are to prevent these diseases more effectively.

Prevention is better than cure

Social inequalities are not a matter of chance or fate. They are the result of political and economic choices that can be corrected. What is socially constructed can be socially deconstructed. To overcome diseases, we need to act on the root cause of the problem, i.e., resolutely tackle the social inequalities that feed and exacerbate them. To get back on track and put an end once and for all to HIV, tuberculosis and malaria as global health threats, we need "above all an ironclad commitment to fight the inequalities that fuel them . This is a challenge we can and must take up", rightly state Peter Sands and Winnie Byanyima.

Given that such a prospect inevitably involves reform of the global economic system and better redistribution of collective wealth, it will not be without its share of obstacles and misgivings. These must be considered while also taking into account the tension towards an ideal of social equity. The effectiveness of such an ideal would make it possible to broaden and revitalize the range of social determinants of health. For, let us repeat, reducing social inequalities on a global scale is the main viaticum or "Last Rite" against health vulnerabilities and the related inequality of lives.

The appeal of this approach lies in the fact that it treats the pain rather than the illness. It is fundamentally more preventive than curative. Better still, it suggests prioritizing systemic and sustainable solutions rather than relying on circumstances. It is not charity that provides lasting solutions to problems, but social justice/equity. In any case, there is a pragmatic and ethical precedence for justice/equity over charity. And as a Baham (Cameroon) proverb says: "If you want to help your neighbor who is hungry, give him seeds rather than roasted maize". The more countries are divided by social inequalities, the less effective they will be in combating disease and pandemics. A global community characterized by great disparities cannot remain healthy.

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