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Feature Article

Social justice, health equity, and mental health

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Abstract

There is considerable evidence to indicate that stigma and discrimination against people with mental illnesses are widely prevalent across nations. Research also shows that individuals with mental illnesses are likely to die 15–20 years younger than those who do not have these illnesses. In addition, they are more likely to experience delays in help-seeking leading to poor outcomes and are more likely to experience physical illnesses. Stigma and discrimination appear to play a major role in depriving people with mental illnesses of their basic rights. Their economic, political, social, and human rights are often ignored. In this article, we describe the capability to be healthy and basic principles of social justice related to mental health. We discuss findings of discrimination often embedded in laws of countries around the world in the context of basic human rights. We believe that clinicians have a key role as advocates for their patients. Clinicians and policymakers need to work together to bring about social and health equity.

Keywords

Human rights, right to employment, right to inherit, right to marry, social justice

Healthcare systems vary across the globe on a number of parameters from ease of access and availability to the financial and personal costs that may be incurred by the individuals who use them. These variations can be the result of varying degrees of investment by governments. Specific cultural variations may also exist in the delivery and take-up of services. In addition, there are specific challenges for mental healthcare and services across countries. Even if similar psychiatric interventions are available, these variations can be particularly problematic because models of mental illness vary across cultures. These explanatory models are influenced by cultural factors relating to how and where people learn and express their explanations of distress, as well as how they see the causations of their distress and the appropriate interventions that may be available. These

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explanatory models as held by the patients, their families, and carers vary from supernatural causes to psychological and a variety of combinations. These explanations therefore can impact upon how distress is expressed and where and who the help is sought from. In many healthcare systems, people with severe mental illnesses end up in prisons which in several countries may well work as asylums without treatment. Stigma, both external and internal, can delay help-seeking as well as subsequent therapeutic engagement. Furthermore, stigma can lead to discrimination which can be embedded in law and can impact treatments offered and accepted. Delays in help-seeking influence therapeutic engagement and lead to poor outcomes. In addition, discrimination can cause the basic human rights of individuals with mental illness to be usurped. Basic rights which many of us in many high-income countries take for granted can easily be ignored for certain groups of people, be they religious or sexual minorities, or people with disabilities and mental illnesses, by policymakers, as well other stakeholders.

In this article, we aim to describe the basic precepts of social justice as far as mental health is concerned, presenting some findings of discrimination in law in the context of basic human rights and presenting some arguments in favour of advocacy by mental health professionals. We also aim to propose some ways forward for individuals, institutions, and policymakers.

Background

The concept of social justice is not new. Philosophers, writers, and others have been talking about and writing about social justice for centuries. The concept of social justice relies on building and strengthening social institutions, which may contribute to equity across a number of variables. Social and economic justice go hand in hand.

Social justice is the virtue which guides us in creating those organisations called institutions. When justly organised, social institutions provide us with access to what is good for the person, both individually and in our association with others. Thus, social justice imposes on all of us a personal responsibility to work with others and design and improve institutions. Institutions carry with them the responsibility of improving society in a just way (Guala, 2016).

Social justice accompanies economic justice, which influences the individual and the social order. It is well recognised that institutions determine how much people are paid, for what skills, and how those skills are obtained and maintained as well as contracts and services which go with them. Three principles of economic justice have been described and these include distributive justice, participative justice, and social justice. The Kelso–Adler theory (Kelso & Adler, 1958) describes distributive justice which includes profits and wages; participative justice which depends upon input from labour and capital and social justice: feedback principle. Their interlinking is crucial in ensuring that society works at an equitable level. However, with globalisation and changing international links and context, it is critical to explore and understand these links.

Capability to be healthy

Institutions can thus play a major role in bringing about equity and ensuring that people have access to equitable resources. Ruger (2012) talks about the building blocks of human flourishing which is linked with health capability or capability to be healthy. This is to be seen as a person's ability to be healthy, including health functioning and health agency (Ruger, 2004). Although certain aspects of health functioning are pre-requisites for other types of functioning, it is worth emphasising that individual capability has multiple facets and does not occur in isolation. Furthermore, various genetic, biological, and physical factors will also play an important role in developing and delivering the capability to be healthy. There is no doubt that community or collective choice is important, and interactions across individuals in the context of family, neighbourhood, or larger community can lead to a sense of purpose. As the ongoing COVID-19 pandemic has shown, human beings do have an individual as well as a collective responsibility for health. However, trying to get a collective decision on responsibility for individual health and well-being and capability can be difficult as recent events such as refusal to wear masks have demonstrated. There can be major tensions between the individual capability and collective responsibility as far as health is concerned – largely due to different societies and cultures, and also healthcare systems. In older, perhaps more established, democratic systems, the tension between individual rights and collective responsibility and response can be problematic and need careful navigation. In publicly funded systems such as the National Health Service in the United Kingdom, rights and responsibilities do get muddled. A further dialogue on the social contract and individual responsibility needs to happen. In medicine's social contract between the patient or the public and clinicians, lies the funder, be it the government or the insurance companies. This tri-partite contract can help deliver healthcare in an equitable way and link individual and collective responsibility.

A key question is where and how these decisions related to rights and responsibility are made and shared. In her observations, Ruger (2012) raises multiple significant questions. Differences between potential health and actual health and agreement, be it with individuals or with a group (which could be seen as a social contract), is also worth exploring especially in specific cultural contexts, as cultural values and perceptions vary across countries. The discrepancy between expectations of what good health is and what can be achieved needs careful exploring. For example, even when an individual is aware that dirty water causes illnesses, not having means to get access to clean water due to a lack of resources can create such a discrepancy. This capability to be healthy can be very strongly influenced by public health policies and access, which in turn are affected by available resources. Achieving equity between individuals and across communities is crucial, but many disparate factors will need to be considered, not forgetting ethical aspects. Geo-political and social determinants of health play a key role in this context.

Social determinants of poor health include unemployment, poverty, poor housing, overcrowding, lack of access to green spaces, and poor quality transport, among others. These factors can all contribute to poor health. Ruger (2012) points out that precise societal mechanisms which influence health are not well understood. Furthermore, she goes on to emphasise that even in the light of existing information on social determinants of health, simply flattening socioeconomic inequalities may cloud subtle nuances. Hence, it is crucial that these determinants and their impact must be considered at community, kinship, family, and individual levels.

Equity and equality

Klein and Huang (2010) have described four concepts of difference which are disparity, inequity, inequality, and burden. Disparity is the quantity that separates a group from a reference point by measuring rates of ill health. Inequity is defined as a difference in allocation of resources, whereas inequality measures the degree of association between differences in rates between groups and the distribution of the population among groups. Burden refers to how many people in a given population are affected and what tehir health needs will be.

The World Health Organization (2021) defines equity as the absence of unfair, avoidable, or remediable differences among groups of people, whether these groups are defined socially, economically, demographically, or geographically or by other dimensions of inequality, for example, sex, gender, religion, race, ethnicity, disability, or sexual orientation. Health equity is achieved when everyone can maximise their full potential for health and well-being. Health and health equity are determined by the conditions in which people are born, grow, live, work, play, and age. Needless to say these are also influenced by biological and genetic factors.

Structural determinants, such as political, legal, and economic, as well as social institutions (which create processes and norms by which people have to abide), tend to become institutionally deviant by hanging onto power and resources for the benefit of few. These structures and institutions also affect people's living conditions by discrimination, stigma, prejudice, and stereotyping. A key task for policymakers and advocates is to identify systemic inequity and to eliminate it. Some groups are not involved in full representation in such decision-making which makes them peripheral and difficult to engage, thus creating a perpetual negative loop.

We need to recognise clear differences between equity and equality. The latter focuses on each individual or a group by giving them the same resources or opportunities, whereas the former sees each individual as being different and thus allocating resources according to their need to facilitate an equal outcome. Social systems are not naturally equitable. Hierarchies get formed over time because of various reasons. Some hierarchies form naturally and others are enforced, and these may well rely on political or economic factors which then get embedded in power. An understanding of historical factors and how these originated and developed privileges for one group or one set of individuals over another is important in trying to eliminate discriminatory practices. The most obvious example is related to race and institutional racism in many countries but equally applies to gender, sexual orientation, and religion. As a result, various institutions which are responsible for social justice often unthinkingly both tend and continue to reward specific groups for so long that the unintentional privileges become rooted, fossilised, taken for granted, and discriminatory. Equity offers to address social systems to rebalance them. Social justice brings in equity and takes this notion one step further by changing the system through changing its institutions in a way that these alterations are long-term and sustained.

The Centers for Disease Control and Prevention (CDC, 2007, 2020) also sees equity as offering opportunities to everyone to be as healthy as possible. There is little doubt that the route to achieving equity in health has to be through just and equitable approaches. A big challenge in such an approach is to be aware of discrimination and discriminatory practices which can be explicit as well as implicit and can occur at either or both institutional and individual levels. All the right policies at institutional or national level may be in place, but it is at an individual level where people may choose to accept, work with, or ignore and work against equity and its principles.

Health equity is a desirable goal or standard which entails special efforts to improve the health of individuals who have or continue to experience social and/or economic disadvantages.

The simplest example to distinguish equity and equality is related to giving people an opportunity. For example, equality is giving everyone the same pair of glasses (whether they need it or not), whereas equity is giving everyone a pair that works for them. This can be compared to the notion of colour blindness towards race which is encouraged in many settings. This notion is seen as treating everyone the same, which in principle is attractive but in practice can ignore individuality and individual needs. Individuals carry with them different sets of burden, pressures, expectations, and resources. Equity means a clear acknowledgement that not everyone in a society or even within the same group starts with same privileges or positions. Some individuals will face more adversity than others and may even have better and more resources, whereas others will not. Equity takes historical and other factors into account in determining what is fair. Equality is based on the belief that all individuals should have some opportunities to achieve a productive and enjoyable life. Equality means access and distribution of a set of resources evenly across individuals of a population, whereas equity is the access to resources or distribution according to need.

Bhugra (2016b) argues that no individual who has an illness – be it mental or physical, acute or chronic – should be discriminated against. However, this raises certain questions about social responsibility as well as the individual responsibility which are embedded in each other. Thus, a social contract between medicine and society makes mutual expectations and management and delivery of these expectations clearer. Sustained inequality between individuals on the basis of illness, disability, religion, sexual orientation, or any other measures of diversity can lead to labelling, stigma and discrimination while cementing privileges for one group which is unlike the others. Social discrimination, for example, against people based on their sexuality, can thus get embedded in the system and, therefore, can be pervasive and intrusive. As a result, it can stop people from reaching their full potential whether in social functioning or health as they are both interrelated, for example, with the stigma surrounding people diagnosed with HIV in the 1980s and 1990s. Social discrimination against people with mental illness remains a major global challenge. It inevitably leads to poor social functioning and, more importantly, labelling them changes their identities. Micro-identities related to race, gender, age, religion, sexual orientation, and other components all get trumped by the label of being mentally ill and people may face a number of discriminatory acts as a result.

Some clinicians have claimed that incorporating a social justice perspective into their work is inconsistent with the apparent neutral positioning of medicine and mental health services, although, as detailed here, the reality is much more complex and, rather than being neutral, services are developed in a societal context and absorb, and often reflect, societal and cultural positions and biases which may be discriminatory or based on a set of precepts which are not neutral (Tribe & Bell, 2018). Examples include the positioning and pathologising of same-sex relationships and consequent diagnostic categories being viewed as applicable to only one gender.

As equity becomes more relevant, clear actions must be taken and the outcome measured. In the context of the pandemic, inequalities have clearly shown higher rates of infections and mortality in certain minority groups. There is considerable evidence of inequity among individuals with psychiatric disorders. For example, they die 15–20 years younger. Often they are not treated as full citizens and are excluded from mainstream society. It is well recognised that geopolitical and social determinants of health affect people with mental illnesses disproportionately. Internal stigma and external discrimination both affect those with mental illnesses disproportionately, thereby leading to differences in outcomes.

Social justice

Daniels (2012) suggests that the theory of justice for health and healthcare is about what each of us owes to others in the protection and promotion of health. Furthermore, subsidiary questions are whether health is special? Is there a moral imperative for this? When do health inequalities become unjust and how does the society or the community deal with competing health needs fairly under reasonable constraints? In the context of equity and social justice, perhaps the last question is more pertinent.

The question of moral imperative of health is critical. Public health models should be able to deal with it. The tragedy in the Western allopathic model is often that mental and physical health are seen as independent of each other as a result of Cartesian mind–body dualism. Hence the idea of social justice for mental health becomes even more important. Keeping people healthy to normal functioning processes has a clear moral imperative. In distinguishing between disease and illness, Eisenberg (1977) makes a clear distinction between disease and illness. Disease or dis-ease is described as pathology which is what doctors are trained to identify and are interested in, whereas illness is about conversion of symptoms or distress to impaired social functioning which is what patients are interested in. Anecdotal evidence suggests that patients can live with their symptoms provided they can keep a job, get some money, have housing, employment, and relationships.

Health therefore sustains individuals and helps them function as well as possible. Thus, health, healthcare, and social functioning have to be seen in an integrated way. The tragedy often is that individual doctors or clinicians tend to focus on amelioration of symptoms rather than the patient's social functioning. Fair equality of opportunity in access to jobs and opportunities is one of the principles of justice. Therefore, when people with mental illnesses are not allowed to have an equal opportunity in access to employment and participation in a society, it undermines the civic society. Daniels (2012) highlights Rawls (1971) theory. This argues that we should not seek to determine what we owe each other by measuring our satisfaction or welfare but focus on our levels of well-being by measuring outcomes using accessible measures. For Rawls, this includes rights, liberties, powers and opportunity, income and wealth, the social basis of self-respect (which are likely to be related to employment, housing, and full participation in the society, which will all contribute to positive self-esteem and positive self-image). There are additional issues related to the perceived and real need of healthcare demands. Population or public health including mental health depends on a number of factors including culture, social organisations, resources, governmental ideology, and consequent policies. Thus, the capability to be healthy at the governmental level relies on resources allocated to healthcare and prevention of ill-health, and policies which affect these to ensure that people have the right information to improve and maintain their health and access to meet their health needs. Equity is needed at all levels if it is to work at an individual level. The capability to be healthy at an individual level is influenced by biological, psychological, and social factors, especially in the context of mental health and well-being. Thus socio-economic, educational and other factors may play an important role in prevention of illnesses.

Justice requires that all societies meet healthcare needs of all their populations fairly, recognising that there may be resource constraints (Daniels, 2012). There will never be adequate resources for healthcare and public health. Hence, some degree of allocation is necessary and this often depends on a number of specific social, economic, and political factors. Even if the laudable aim is to provide equality or equity, in reality this fails largely because there may not be a clear consensus between the government, medical professionals, and public. Often, decisions are made on the basis of outcomes due to specific treatments or on the basis of loud demands by interested parties, or any number of other factors. Some degree of rationing may occur explicitly or implicitly. Daniels (2012) describes four conditions which can help make the right decisions to reach fairness and legitimacy. These include publicity, relevance, appeals, and enforcement conditions. Health promotion can facilitate the capability to be healthy at an individual level, and this confirms Daniels' (2012) observation that we owe each other comprehensive measures to reduce health risks and to distribute them more equitably. Social justice can help manage social determinants of health in a more equitable manner.

Discrimination

In a series of studies, Bhugra, Pathare, Joshi, et al. (2016c; Bhugra, Pathare, Gosavi, et al., 2016a; Bhugra, Pathare, Nardodkar, et al., 2016b; also see Nardodkar et al., 2016) examined the laws of 193 countries. This group was interested in looking at personal, economic, and political rights of people with mental illnesses. They looked at four areas of rights: to inherit property or to make a will, the right to marry, the right to employment, and the right to vote of individuals with mental illnesses. All 193 countries were signatories of the United Nations Charter on Rights of Persons with Disability, but the number of rights given to people with psychiatric disorders were often very low. The group identified relevant provisions of legislation using key terms or combinations of key terms listed below. For non-English versions of legislation, if an authoritative English translation was available, it was used for analysis. In other situations, translators were used to translate key terms and pertinent provisions of legislation. If basic acts were not available, non-codified and secondary sources of information such as government reports, academic articles were studied. Any mention of mental illnesses and mental health conditions in laws were identified using the following keywords: *mental*, *unsound*, *mind*, *insane*, *sane*, *mad*, *cognitive*, *intelligence*, *infirm*, *imbecile*, *dementia*, *demented*, *full reason*, *deficient*, *derangement*, *disturbed*, *defect*, *capacity*, *incapable*, *ability*, *disability*, *disorder*, *disease*, *illness*, *disturbance*, *handicap*, *health*, *fitness*, *sickness*, *capacity*, *lunatic*, *family*, *impediments*, *requirements*, *curable*, and so on. The reported findings were truly worrying as only a minority of countries allowed all four rights, and there were clear variations.

The findings concluded that individuals with mental illnesses cannot live equitable lives in the four areas of rights that were investigated. This can contribute to an inferior quality of life, lower status, and a sense of not belonging, as well as of alienation for people living with mental illness. Consequently, the World Psychiatric Association produced a Bill of Rights (Bhugra, 2016a), and it was signed by 60 national and international organisations. Another initiative that emerged subsequently was the development of a Magna Carta for people with mental illnesses (Persaud et al., 2021). These authors recommend that any progress in health, economic, environmental, and global development will be associated with improvements in mental health. Mental illnesses not only lead to difficulties at an individual level, such as increased morbidity and mortality, but also cause damage to the economy, and hence, every country needs to take urgent responsibility for defending the rights of individuals with mental illness.

Conclusion

The concept of social justice is continuing to evolve, especially in relation to mental illnesses. It is not equitable that those who go onto develop psychiatric disorders are legally discriminated against. The challenges to social equity and the application of social justice are many and remain entrenched in cultures particularly in respect of people living with mental illnesses. Clinicians need to lead by example to reduce discriminatory actions and policies so that those with mental illnesses can lead fully functioning normal lives. Health professionals have a moral and an ethical duty to advocate for individuals who may not have a forum to speak at. They must look at and develop social contract if it does not exist. This will ensure that patient expectations, as those of their families' and carers are met appropriately, adequate resources are made available and principles of equity are embedded in law. Health professionals, no matter what discipline they belong to, have a responsibility to ensure that the terms of the social contract are agreed, and consequently, roles, duties, rights and responsibilities are clear and understood. Then, only discrimination can be tackled and individuals with mental illnesses can lead normal and full lives with principles of health equity supporting them.

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