

“FROM THE COMMUNITY” HEALTH:

**NON-STATE COMMUNITY HEALTH
SYSTEMS AS A POSSIBLE STEP IN THE
PATHWAY TO FUNDEMENTALLY
RESOLVING HEALTH INEQUALITIES
RATHER THAN AMERIOLATE THEM.**

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Acknowledge traditional owners and reflecting where most Australians come from....and our treatment of 'new arrivals'



What am I trying to say?

Conference Theme:

Creating healthy societies through
inclusion and equity:

What I'm trying to say:

Promote inclusion in society and promote
equity and “health” will be created.

How am I going to say it?

Presentation layout

- a) Theory- very briefly 3 parts;
 - Health inequalities/inequities
 - Actors (Governments and Trans-national Corporations and Non-state health systems)
 - Further thoughts and problems.
- b) Practice: some “from the community health systems/movements” and a quick focus one of the best ...the Aboriginal Health Service!
- c) Story telling:- Backpack Health Care Workers/ HMS Woomera
- d) Quick Plug: Some info re local initiative /questions and comments

Health: what is it?

- If we are trying to describe equity in health then we need to have some agreement of “what is health”.
- On a spectrum? Narrow and Broad definitions.
- **Health is?**
Health to Aboriginal peoples is a matter of determining all aspects of their life including **control** over their physical environment, of dignity, of community self-esteem and of **justice**.
(National Aboriginal Health Strategy Working Party Report 1989:ix-xiii)
- **Health is?**
A state of complete physical, mental and social welling, and not merely the absence of disease or infirmity
(WHO 1978)
- **Health is?**
Labor power and resources such as numbers of doctors and infant mortality rates.
(Koivusalo and Ollila 1997)

Health

- A broad and socially inclusive definition of what health is, implies that action on health inequities will also be suitably broad.
- Health is created and maintained primarily outside of the “health” system...eg transport, education, environment (! Very significant point!)
- Therefore to address health inequities should we also focus outside health systems?

Health Inequalities

- Are present across 'developed' and 'developing' nations and within them.
- Are not discrete. Not just rich and poor, but Marmot's concept of a social gradient.
- Have been well researched but less well acted upon
- ARE GETTING WORSE!

Why a focus? Maybe have become a basis for Western scholarship because of the failure to improve health and distribute the increasing wealth in developed nations...health inequities have a long colonial history.

A fantastic body of theory from the South, we could learn a lot from them!

Actors: Trans-National Corporations (TNC)

Their rising influence and effects on health (often in concert with States)

- The privatization of previous state monopolies and key services
- New trade regimes (TNCs suing Governments in the WTO)
- In the developing world, the 'race to the bottom'.

Globalization may have profoundly deleterious effects on some states and may well increase inequality among them. The erosion of sovereignty may mean that states cannot protect their industries and local employment; that laws protecting the environment and the health and safety of workers are weakened; that social spending is reduced; and that national economies are controlled by the flow of international capital.

Kunitz, S., J., "Globalization, States, and the Health of Indigenous Peoples" In American Journal of Public Health, October 2000, Vol. 90, No.10, 1531-1539

Do TNC's have any interest in Equity?!

Or are inequities profitable for them (eg more \$2 a day workers)



Polyp: New Internationalist Website

Governments/State acting on Health Inequities

Positives:

- Redistributive efforts such as tax
- Coherent policy
- Politically motivated to maintaining “health” at some level

Negatives

- Concentrations of power and beurocracy
- Globalisation and the selling off of public goods (link between States and TNCs)
- Exclusion/indifference at those at the margins, Indigenous peoples, “illegals”, mentally ill, drug addicted, sex workers etc

Or the State as a source of Insecurity?

Similarly **unpromising** are approaches that rely overmuch on appeals to governments: careful study reveals that **state power** has been responsible for most human rights violations and that most violations are embedded in "structural violence"--social and economic inequities that determine who will be at risk of assaults and who will be shielded

“Pathologies of power: Rethinking health and human rights” Farmer (1999:1486)

Non state “from the community” health systems have potential to fundamentally address inequities:

- Their agendas often match the community’s agenda
- They address marginal communities (often focus on those surviving at the “bottom”) and in doing so name systems of power and oppression
- Having emerged from communities are often acceptable to them (the 88% drop off in best practice efficacy due to decreased consumer acceptance...wow!)
- In being guided by communities, address sources of ill health rather than downstream factors
- Are working in the complicated and chaotic laboratory of the real world
- If they are non-hierarchical, they can be healthy to work in too! (unlike working for the British public service on Marmot’s watch!)

?A lesson from Development studies: That the way (process) in which we address health inequities is an important step to resolving them (outcome).

Community health? Is it a way forward?

It is also important to recognize that community based public health initiatives can be amerolative rather than fundamental....

In fact, aspects of the structural paradigm [of addressing health inequalities] urge working in partnerships in communities, engaging in bottom up approaches, and recognizing that historically important and effective social movements derive their moral, political and practical force from the autonomous networks and institutions developed and kindled within minority communities.

(Geronimus 2000:870)

Aboriginal Health Service

The early 1960s, Aboriginal and Torres Strait islanders initiated political action...

-Yirrkala bark petition in 1963

-Walk off from Wave hill 1966

-Tent embassy 1972...then Mabo and Wik

Health as part of this history of political engagement?

In 1971 the first Aboriginal health service started in the back of a shop in Redfern, inner city Sydney.

Other communities evolved similar models (Fitzroy 1973, Perth 1974 and Alice Springs 1974)

1987-1989 National Aboriginal Health Strategy largest consultation about Aboriginal health ever undertaken in Aboriginal communities (but set up to fail- chronically underfunded)

A decentralised health service, with every community having a form of health service

1989 NACCHO – concepts of community controlled health. Before Marmot's ideas on control and health had influence!

Barely Equality let alone Equity!

1995-96 about 2% of all Australian recurrent health expenditure was for ATSI people, \$2,320 per ATSI person (\$2,163 non-ATSI) -This is despite a mortality rate three times higher than that of other Australians.

There still remains a huge gap in health between Indigenous and Non-Indigenous people. This gap has not improved significantly in the last 20 years. I can expect to live 20 years more than an Indigenous man! That's 20 years more life!

Other examples:

Women's Health: “The Women's Health Movement succeeded in demonstrating that improvement in women's health care depends not just on technological advances in medicine, but on social politics and practices that eradicate poverty, sexism, racism, homophobia and other forms of discrimination and injustice’

Morgen, S. (2002) *Into Our Own Hands: The Women's Health Movement in the United States, 1969–1990*. New Brunswick, NJ: Rutgers University Press.

RASHN: Refugee and Asylum seeker health network (Melb)

RaveSafe: Drug and Alcohol harm minimisation at “Doofs”

Story telling case studies: (both involve backpacks!)





HMS: Woomera

Provided health support for over 1,500 protestors who were engaged in Civil Disobedience at Woomera Detention centre in 2002.

HMS Woomera is a self-funded, grassroots collective, which treated over 250 people during the long weekend.

It was established upon a basis of free, universal health care for all, equity, access, community empowerment and participation



Back Pack Health Workers (on the Thai Burma border)

Provide health care services to civilians in the “free fire areas” where the Burmese Military and Insurgents are operating.

Funded via various NGO and Gov't grants but the organisational structure and decision making is all local people

Train local people as health care workers

Health Workers go out and live in the communities for months at a time

Strong networks with other community agencies such as refugee camp clinics, education services



Pros and cons of self organisation:

Advantages:

- Workforce motivated, own the decision making process
- Local generation and application of policies
- Patients can be more involved in decision making and co-ordinating care
- Local control saves beurocratic duplication, more economical
- High degree of local autonomy makes large structures manageable
- Local control reduces “disastrous hands on” of politicians at the centre

Obstacles

- Health professionals may lack reflexive skills
- Public and media pressure for centralised accountability
- Politicians and beurocrats will not give up power easily
- Self organisation requires that autonomous agents are trusted by the community
- Requires sophisticated internal and external feedback loops, such systems are poorly developed.

The self –organising system” as a model for primary health care – can local autonomy and centralisation co-exist” Pritchard 2002 Informatics in Primary Health care 10: 125-34

Questions of these “Non-state” health systems

- Do they have shared features?
- Can we apply an explanatory model?
 - Development studies: Participation Networks
 - Industrial psychology: Autonomous work groups
 - Political activist theory: Autonomous networks/Health Social Movements
 - Informatics and cybernetics: Self-Organising systems
 - My favourite.... Reflecting Human physiology...
The body as a “Federation of Cells” Virchow
- Do they have boundaries or are they on a spectrum
- Where do they come from? Eg emerge from increasing social inequities
- Where do they go too? Eg do they fuse with State run services
- Are they good? (and how do we know they are good)
- **But they do have promise because they engage health socially and politically.**

Strong associations between politics and health

“**Democracy, political rights, and civil liberties** are politically modifiable variables that seem to be **associated with health status**. In our study, democracy showed a stronger and more significant association with indicators of health (life expectancy and maternal mortality) than indicators such as gross national product, total government expenditure, or inequality in income.”

Franco, Alvearez-Dardet and Ruiz, 2004, “Effect of Democracy on health: ecological study” BMJ volume 329
18-25 Dec

Development studies again!

Development is....”The removal of major sources of **unfreedom**: poverty as well as tyranny, poor economic opportunities as well as systematic social deprivation, neglect of public facilities as well as intolerance of the over activity of oppressive states “

Amartya Sen - (Development as Freedom)

Summary:

Health inequities are worsening both globally and within nations

The agenda, structure and processes of Governments and TNCs do not lend themselves to fundamentally ending health inequities

There are many different models to draw on for autonomous health systems, eg organisational psychology, to social science, to cybernetics

Rather than exporting “Development theory” we in the developed world should listen to some of the South.

Non-state “from the community” health systems have great promise as they act on health inequities in ways and processes that are equitable. They are often politically engaged...which could be the right place to push.

It's not new.

These links are far from mysterious; they are merely a restatement of what people recognised long ago, namely, that the important dimensions of the social environment for human wellbeing are, Liberty, Equality and Fraternity.

Wilkinson The Impact of Inequality 2005