



Rethinking power as a determinant of health inequity

Never Stand Still

Medicine

Centre for Primary Health Care and Equity

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New ways of thinking about the social determinants of health
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Overview

- inequality or inequity?
 - difference or unfair, unjust, avoidable social treatment? Who is responsible for the delivery of social treatment? Who decides whether it is unjust and unfair?
- what is unfair, unjust social treatment?
 - economic injustice – socio-economic and political policies (maldistribution)
 - social injustice – ascribed negative meanings attached to social groups that are then incorporated into social patterns of representation, interpretation, and communication (misrecognition)
 - cultural injustice – negative meanings embedded in cultures and societal values, codified in policies and practices

why and where do these injustices arise & what are remedies?

- organisations responsible for governance in government, civil society, and the market
 - policies and practices;
- the people working in those organisations – what and how we think, what we see, what we do, how we act – create spaces for shared meaning, deliberation, and decision-making;
- people in historically marginalised groups – who take on some of the forms of injustice and apply within - create political communities in addition to cultural communities; create own agendas and systems for representation, participation, deliberation and decision-making; and participate in creating spaces for shared meaning, and in deliberation, and decision-making.

what mechanisms lead to the injustices?

- political power exercised through and in social institutions by social actors
 - in government – in legislative and policy spaces
 - in the market
 - in civil society
- political power used in different ways
 - power over (influence or coerce)
 - power to (organise and change existing hierarchies)
 - power with (collective action)
 - power within (individual consciousness)

to make progress

- need to expand the political power of groups that have been historically marginalised:
 - to enable direct representation and participation in decisions about the distribution of the social determinants of health;
 - to demonstrate recognition as equal participants in the structures and processes through which we govern ourselves.

Life expectancy 1960 – 2010

from: WorldLifeExpectancy

	1960 (years)	Rank	2010 (years)	Rank
Japan	67.7	35	82.2	1
Singapore	63.7	45	82.1	2
Australia	70.8	10	81.7	4
Norway	73.6	1	80.1	13
UK	71.1	9	79.9	16
USA	69.8	16	78.2	29
Cuba	64.2	43	77.6	32
China	36.3	162	74.5	64
India	42.3	135	66.5	126

Australian Aboriginal and Torres Strait Islander life expectancy – world rankings in 2010

Life expectancy rankings in 2010 (from: WorldLifeExpectancy)

- For males, equivalent of Ethiopia (159), Kenya (150) , Cote d'Ivoire (157)
- For females, equivalent of Madagascar(140) , Botswana (151)

within Australia

- Between 1901 and 2006 life expectancy at birth for Australians increased by 21.4 years for males and 23.3 years for females

Australian Institute of Health and Welfare. Australian trends in life expectancy. <http://www.aihw.gov.au/life-expectancy/>

- Between 1960 and 2004 life expectancy among Indigenous Australians increased by 8 years for males and by 14 years for females.

Australian Government. Department of Health and Ageing. Aboriginal and Torres Strait Islander Health Performance Framework –2010. 1.17.

- “I have always advocated that the greatest possible assistance should be given to the race from whom we have taken this territory, and to whom we owe a great debt of gratitude for the splendid possession we have. The least we can do is to make their time here, which will not be a very long time, as pleasant as possible, and their departure as gentle as circumstances will permit.”

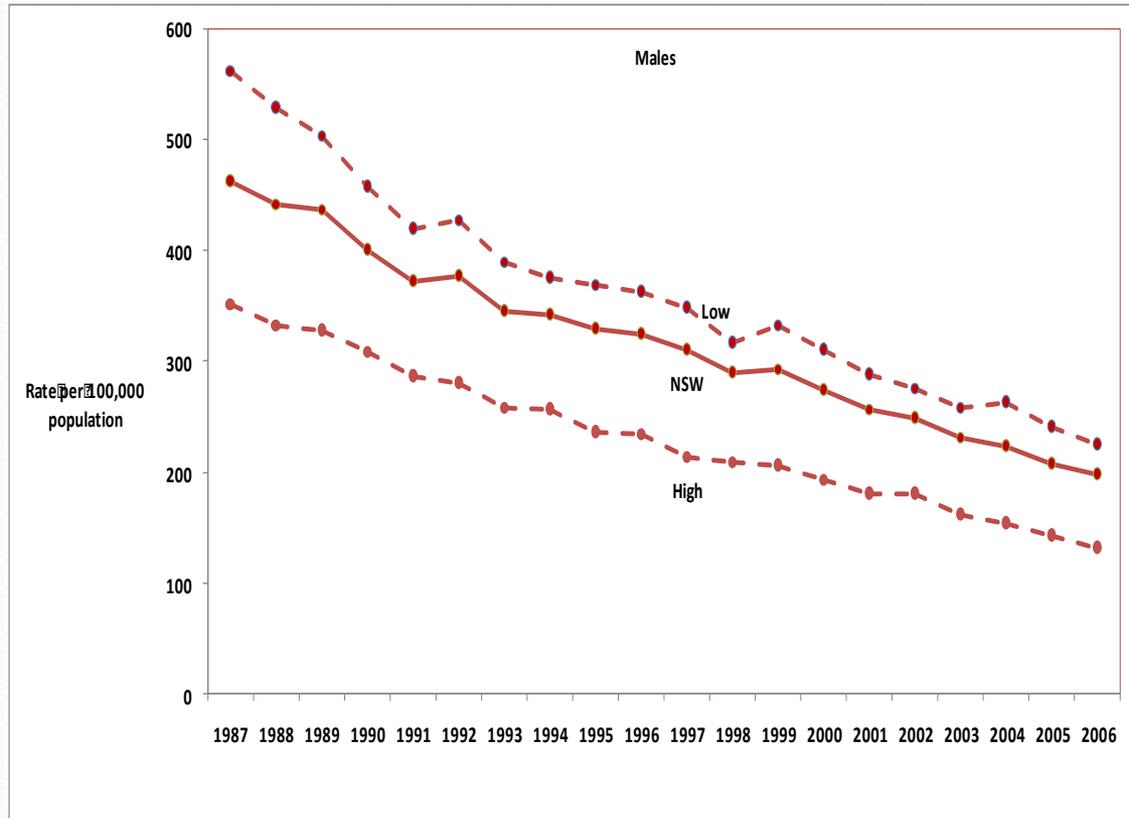
Queensland politician, 1897.

- Between 1901 and 1967 the Commonwealth Constitution Act stated that ‘in reckoning the numbers of the people of the Commonwealth [...], aboriginal natives shall not be counted.’

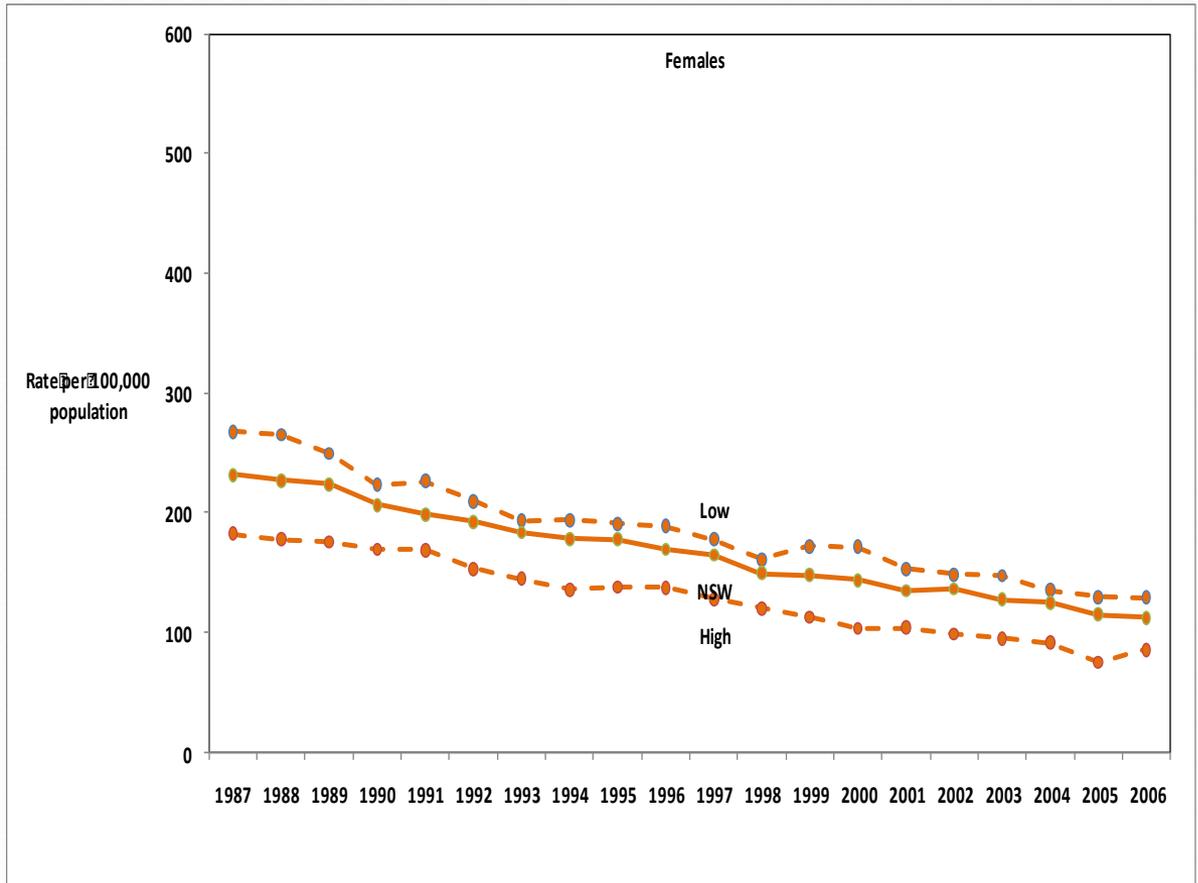
Aboriginal people encountered during the census were asked to complete the census, including stating the proportion of their Aboriginal heritage. If they were more than half Aboriginal they were excluded from the Census results.

It was only after the Referendum in 1967 that this began to change.

Potentially avoidable deaths in highest and lowest socioeconomic quintiles and rest of population: males aged less than 75 years, NSW 1987 to 2006



Potentially avoidable deaths in highest and lowest socioeconomic quintiles and rest of population: females aged less than 75 years, NSW 1987 to 2006



what is health inequality?

- health inequality is a generic term – designating differences, variations and disparities in the health of individuals and social groups.

Kawachi I, Subramanian S, Almeida-Filho N. A glossary for health inequalities. *Journal of Epidemiology and Community Health* 2002; 56: 647-652. p. 648.

- common
- can be desirable (e.g. different dispositions, intelligence)
- can be necessary (e.g. gene pool)
- can be measured, and
- not, inherently, unjust or unfair.

what is health inequity?

- health inequity arises when differences in health are **judged** to have arisen from unfair, unjust social treatment that is ***systematic, patterned, and avoidable***.

Whitehead M, Dahlgren G. Levelling up, part1: concepts and principles for tackling social inequalities in health. Copenhagen: WHO, 2006.

The identification of health inequity is not a scientific matter – it is a judgement conditioned by ethical and moral criteria (values) linked to the political priorities (*of organizations and people with power*) .

equality, liberty, efficiency, security, community

Judgements are based on beliefs about what constitutes social justice

- all humans are born equal and our lives have equal value (foundational equality)
- all citizens have formal rights and entitlements – equality before the law (formal equality)
- all citizens have the right to vote, that one person = one vote, that one vote = one value, and that almost all citizens have the right to stand for office (political equality)
- all people should have equal life chances (equality of opportunity)

and includes beliefs about whether

- inequalities arise from unjust, unfair social treatment;
- they arise by chance or choice – by the random, unequal distribution of merit, talent, determination, and discipline’
- they are desirable or necessary; and/or
- it is the responsibility of the state or society to remedy.

Power is associated with whose beliefs will prevail and is critical to ‘who gets what’.

determinants of inequalities in health

(Whitehead,2000)

1. natural biological variation
2. health damaging behaviour if freely chosen, such as participation in certain sports and pastimes
3. the transient health advantage of one social group over another when that group is first to adopt a health promoting behaviour (as long as other groups have the means to catch up fairly soon);

and determinants of inequities in health

4. health damaging behaviour where the degree of choice of lifestyle is severely restricted; ✘
5. exposure to unhealthy, stressful, living and working conditions; ✘
6. inadequate access to essential health and other public services; ✘
7. natural selection or health-related social mobility involving the tendency for sick people to move down the social scale ?

in other words

- unfair, unjust, social treatment

Redistributing political power as a determinant of equity

- The Commission on the Social Determinants of Health argued that political power needed to be redistributed
 - power for its instrumental value – as a resource that is necessary to abolish (or reduce) differences in opportunities to access and use social and economic resources.
- The Commission identified but gave more limited attention to the need for
 - power for its relational value – as a resource that recognises people and groups as having valued places and roles in society and that confers respect, dignity, and autonomy.

The analysis and remedy did not acknowledge that

- some social groups are systematically, persistently over-represented in low socioeconomic quintiles, and experience **additional** burdens of ill health and premature mortality;
- these groups experience additional injustices through misrecognition and lack of presence in decision-making;

(Fraser N. Rethinking recognition. *New Left Review* 2000; 3: 107-120.; Zurn C. Recognition, redistribution, and democracy: dilemmas of Honneth's critical social theory. *European Journal of Philosophy* 2005; 13(1): 89-126. p. 99.; Phillips A. *The politics of presence*. Oxford: Oxford University Press, 1995.)

- and that the injustices of economic maldistribution, and of social misrecognition are perpetuated by cultural injustices – embedded in the policies, laws, and guidelines embedded in the institutions of governance; and the values, beliefs, knowledge, attitudes, and practices of the actors in those institutions.

what are the characteristics of the social groups?

- group membership is not, usually, experienced as voluntary or mutable;
- negative meanings are assigned to group identity by the broader society or dominant culture; and
- patterns of social and political inequality are structured along the lines of group membership (and are long-standing).

Williams M. Voice, trust and memory: marginalised groups and the failings of liberal representation. Princeton, NJ: Princeton University Press, 1998. p.15-16.

the critical issue is that

- injustices arising from these sources cannot be remediated by the redistribution of socioeconomic resources alone;
- they can only be remediated by recognition and presence;
- it is not sufficient to speak truth to power – it's necessary to 'be powerful' and to have power – not only for its instrumental value, but also for its independent value (respect, esteem, recognition)

What does this mean for practice?

- Lukes famously identified three dimensions of power in societies:
 - being at the decision-making table at which agendas are set, issues discussed, and decisions are made;
 - having the ability to influence which items ‘make it’ for consideration on the public agenda, the ways items are discussed, and the final decisions that are made; and
 - having the capacity to recognise and formulate one’s own and one’s group interests free from the domination of others.

How does misrecognition lead to unfair, unjust social treatment?

What institutions and actors do.

- **consultation** as a remedy for lack of presence (NTER – Little Children are Sacred)
- **evidence** as a remedy for lack of influence on priority setting, deliberation, and decision-making (epidemiological & social data & 5,000 papers on health promotion)
- **evidence** as a remedy for unequal social treatment (CQI or EFHIA)
- **engagement** as a remedy for lack of influence in decision-making (students and NSW Health award re pay and conditions)
- **participation** as a remedy for lack of influence (membership of NSW Health public health advisory committee)

- ***inclusion*** as a remedy for lack of presence (job advertisement by an NGO)
- ***empowerment*** as a remedy for social exclusion/social cohesion (indicators used to measure inclusion/social capital etc)
- ***engagement*** as a remedy for lack of presence (citizens committees)

- some address ***presence but not recognition – others address recognition but not presence***
- none address misrecognition overtly – neither causes (how ‘we’ think and act); nor consequences (what it means for ‘others’)

To make progress: add recognition and presence to redistribution – equal political power

- **Identify groups that have been subjected not only to maldistribution but also to misrecognition leading to social and cultural injustices**
- **Commit to action**
- **Ensure/enable/support the **presence** of the groups in the structures and processes through which we govern and deliver social treatment – in own organisations and in all spheres and levels of governance**

Housing has taken positive steps – Habibis, Memmot et al, Housing conditionality, Indigenous lifeworlds and policy outcomes. Final Report 212. University of Queensland: Australian Housing and Urban Research Institute, 2013.

Support/encourage political communities

- **Support the establishment of political communities – separately from cultural communities**
 - to identify independent interests, to establish own sets of items for the public agenda, and to frame problems, causes, and solutions
 - support and assist political communities to coalesce where necessary – e.g. selection of a candidate for office
 - assist communities to access resources needed to establish their own items for the public agenda and to put items on that agenda

Indigenous Governance Project, Toolkit and Case Studies. CAEPR and Reconciliation Australia.

<http://caepr.anu.edu.au/governance/index.php>

Dialogue, Deliberation, & Public Engagement Master Class. (www.activedemocracy.net)

Analyse and change current institutional policies, practices, and norms

- what values, norms, and rules are codified in policy and institutional practices that are creating or perpetuating inequity;
- who are the actors – are any from the group(s) of greatest concern
- what are the values, assumptions, knowledge, and experiences of the contemporary actors in those institutions?
- **develop a Reconciliation Action Plan – review and reflect on own knowledge, attitudes, beliefs, values and those of our organisations**

Reconciliation Action Plan (<http://raphub.reconciliation.org.au/>)

Aim for descriptive representation in decision-making

- mandate proportional representation - presence
- **define what 'representation' means – who is representing whom? Who decides? How are issues raised, discussed, agreed upon, and conveyed?**
- collaborate to optimise recognition and influence

Create recognition spaces, take time, reach consensus

- **create safe spaces and take time for deliberation – reconciliation spaces and processes**
- identify cultural and experiential differences and similarities
- formalise use of deliberative methods (Talk Out Loud; citizens' juries; listening posts;)
- work together – and make spaces for others
- the more we face a question of basic rights or justice, the more important deliberation becomes and the less that question should be settled on the basis of power – even equal power.

(Mansbridge)

Aim for substantive representation

- representatives have placed community-driven issues on the agenda
- representatives are actively engaged in deliberation and decision-making
- **and the decisions have led to desired results *even at the expense of (or in comparison to) the majority.***

- Paul Keating said: ‘I think it begins with that act of recognition’.
- Health is holistic, the outcome of multiple inter-related factors which can be spiritual, environmental, ideological, political, social, economic, mental, and physical. When the harmony of these is disrupted, Aboriginal ill health will persist.

Everything old is new again

- reflecting on our own roles in creating and/or perpetuating inequity is a critical next step;
- to look within ourselves and our institutions and to examine our actions;
- and to create (or vacate) spaces so that the people who have been denied social justice can take their rightful places in determining the future – not only their own future but everyone's future.

No matter what language or theory we use

- inequity is an outcome of avoidable, unfair, unjust social treatment – but who decides?
- inequity is not only an outcome of decisions that result in the unfair, unjust distribution of social resources
- inequity also arises as a result of lack of recognition and presence in social decision-making both because:
 - groups cannot represent themselves and their needs in decision-making (wrong problems/wrong solutions);
 - and lack of presence denies recognition – dignity, esteem, and autonomy
(Honneth A. The struggle for recognition: the moral grammar of social conflicts. Cambridge, Mass: MIT Press, 1996)
- redistribution, recognition, and presence are essential to ensure equity and social justice