HEALTH AND ILLNESS
Lecture 2

HEALTH AND POWER

In the previous lecture we considered the individual's personal view on health and illness affected by such as cage, culture and gender. In this lecture we are going to look at the influence of various power groups on our ideas of health and illness.

HEALTH FOR ALL

The influence of various groups in Society on our attitudes and the power they have to determine the provision of health care.

Factors which influence good health

In 1978, the WHO issued a challenge to the world to attain health for all by the year 2000, and subsequently - in 1986 – their European office defined 38 health targets:

WHO Health Targets

The pre-requisites for health

- Peace
- Social justice
- Adequate and wholesome food
- Safe water
- Decent housing and sanitation for everyone
- Education for Everyone
- Secure employment so that everyone has a valued and rewarding role in society.

The targets

- ***Equity, in health*** so that everyone has the best possible opportunity to develop healthily and to obtain required health care.
- ***The addition to years of life*** by the prevention of premature death
- ***The addition of health to life*** so that preventable disease and disability are minimised
- ***The addition of life to years*** so that the highest attainable level of health continues to be enjoyed by both the elderly and those disabled by chronic illness or permanent impairment.
- ***Identification and promotion of healthy behaviour*** and the discouragement of unhealthy behaviour
- ***The introduction of polices*** in all sectors of public life to take it easier to adopt healthy lifestyles and to participate in health policy-making, and to enhance the family or other social groupings
- The creation and preservation of a ***healthy environment***
- ***The development of health services*** which are appropriate to people's needs and wishes

- ***Acceptance of these goals*** by those responsible for research, for service management and for training within the health professions

The most recent **Health21**: The health for all policy framework for the WHO European Region (WHO, 1999), where 21 targets were defined. *(Refer to attached Annex 1).*

The new health for all policy framework for the WHO European Region is the result of a very extensive two-year process, during which drafts of the document were reviewed and input received from Member States, WHO networks and forums, United Nations agencies, international and integrational organisations, nongovernmental organisations and individual public and private sector experts.

Extracts from the World Health Declaration (Adopted by the world health community at the Fifth-first World Health Assembly, May 1998):

> *We recognise that the improvement of the health and well being of people is the ultimate aim of social and economic development. We are committed to the ethical concepts of equity, solidarity and social justice and to the incorporation of a gender perspective into our strategies. We emphasise the importance of reducing social and economic inequities in improving the health of the whole population. Therefore, it is imperative to pay the greatest attention to those most in need, burdened by ill-health, receiving inadequate services for heath or affected by poverty. We reaffirm our will to promote healthy addressing the basic determinants and prerequisites for health. We acknowledge that changes in the world health situation require that we give effect to the "Health-for-All Policy for the twenty-first century" through relevant regional and national policies and strategies.*

The action needed to achieve targets such as these on a large scale can be taken only by groups of people with enough power in society to carry them through. Having the power to bring about action usually means also having the power to influence *how* the action is taken.

GROUPS WITH POWER

One of the basic beliefs of a democracy is that each individual should have an equal voice, but in practice if millions of equal voices are all proclaiming different ideas, they will convey no great message. It is much more effective to form a group with other people who think similarly and then put the message across with the power of the group behind it.

A society in which there are groups with different points of view, all having some degree of power is known as a pluralist society. Power between the groups including, those in government and other official positions. In pluralism no group is totally excluded form a having a voice in the decision-making as each group has some resources that enable it to

have power (Ham, 1977). Some use the media to increase awareness and gain support; others may take legal or even illegal action to raise awareness of their cause. Although the power is not shared equally between the groups any group can make its voice heard (Dahl, 1961).

The more power a group has in society as a whole, the more influence it will exert.

Factors, which give a group power

Four Headings

- ***Political***
- ***Professional***
- ***Economic***
- ***Representational***

POLITICAL POWER

Any political group in power, even in democracy, which has voted it into government, will exert a tremendous influence on perceptions of health. The National Health Service was a dream realised by those whose political beliefs focussed on the right of everyone in society to free social welfare and health care. It was set up to ensure that everyone in Britain had equal access to health care, regardless of his/her financial circumstances.

A system based on economic considerations as introduced by the Conservative Government in 1991 is different, because it is based on the belief that everything has a price. These reforms were part of wider policy aimed at introducing a greater element of market discipline into the public sector.

Infinite Demand – Unlimited Funds?

Health is not a tradable commodity; it cannot be bought and sold in the market place, and this raises problems in trying to decide what level and sort of health should be available.

In 1991, in an attempt to answer criticism that its policies would lead to a reduction in the amount and quality of state-funded health care in the UK, the government published ***The Patient's Charter*** *(refer to Appendix 2)*. This set out what the government saw as the basic health-care rights of every individual, and is therefore a statement by one group with power about what healthcare should be.

(The Patient's Charter published by the Hospital Management Committee of Malta is also attached)

Owen (1976) pointed out that public opinion does not always choose the same priorities, as do those in government and management, whose job is to plan the health service.

How much health care should people be entitled to?

Health care, as any economic system of production and distribution, starts with the assumption of scarce resources. This means that there are not enough goods – in this case health services – to enable everyone to consume what they would like. Whether health care is a personal or national responsibility there is one basic truth: we can only spend what we can afford.

State-Funded Care

If society should provide health care for all its members, for which they pay throughout life by taxation according to their means, then government can only spend the money it has available. To have more money available it will have to increase taxation. Overall, however much money a government has, it will have to make decisions on what proportion of that money goes to education, health and so on.

In the European Region, the nature and role of governments is slowly changing, moving away from the direct provision of services and support for populations towards establishment of a framework of societal objectives and regulations within which there exist many providers, both public and private. There has also been a move to decentralise, with responsibilities being increasingly left to regional or local structures.

Governments, however, still bear the ultimate responsibility for the health of their people, and for the use and outcomes of overall resources for health and health care.

Thus what a country can afford to spend on health is a political decision. Example: If a country cannot afford the technicians necessary to scan cervical smears adequately, leading to a reduction in the number that can be done, the perception of health as a positive state may be reduced.

The whole idea of what health is, not only influences political decisions but also is influenced by them. It is easy to see how a generation of women who have not had the benefit of screening may have lower expectations of what good health can mean than those who regard gynaecological and other health screening as part of a healthy lifestyle.

As health care is provided, so expectations rise; as technology improves people with disabilities and chronic diseases live longer and demand more health care. General improvements in health and living conditions have led to people living longer and demand more health care. General improvements in health and living conditions have led to people living longer and an increase in the percentage of older people in the population. It will not be possible to meet all these needs, as resources are limited. It follows that there needs to be a mechanism for distributing these scarce resources in some way. This mechanism is often referred to as 'rationing'. (An example is transplant surgery)

Choices/Rationing

The outcome of these issues is that choices will have to be made about what is a ‘reasonable’ level of health care and what is not. Health-care professionals and politicians are already making these sorts of choices in a limited way. Where is the cut-off point for providing stat-funded health care for all members of society?

Most doctors and health care workers accept that some kind of priority setting or rationing of health care is inevitable. There always have been waiting lists but rationing is more far-reaching concept. It entails decisions about how much money would be put into different forms of care or treatment. Not only does this raise issues about justice and equity, it also poses the huge dilemma about who decides the priorities for investment. Public views may be very different from those of doctors and other health care professionals. For example, infertility treatment may highly by the public but not by doctors who are more in a position to question its effectiveness.

As a qualified nurse you may be involved in the process of deciding what care is reasonable to expect that state to fund and what conditions, or groups of patients will be excluded.

PROFESSIONAL POWER

We have said that the NHS is intended to be available to anyone who needs it. ***Do health professionals have any say in defining and identifying need?***

The influence and power that the medical profession has on people’s view of health and illness

The Biomedical Model
In the West, the dominant model of disease is the bio-medical model. This is based on the assumption that disease is generated by specific aetiological agents which lead to changes in the body’s structure and function. The medical view of the body is based on the Cartesian philosophy of the body as a machine.

Hence, if a part malfunctions it can be repaired or replaced: the disease is treated, but not the illness, which is subjective experience of dysfunction. It seems the mind and body as functioning independently, and while disease may lead to psychological disturbances, it does not have psychological causes. The model is based on an assumption of scientific rationality, an emphasis on objective, numerical measurement and an emphasis on physical and chemical data.

There have been challenges to the traditional medical model, which sees health as the absence of disease. It focuses too narrowly on the body and on technology, rather than

on people in the social context in which they live. These challenges have been made mainly by social scientists who view ill health as being caused by a combination of biological (e.g. genetic predisposition), social (e.g. poverty) and psychological factors and predispositions.

The menopause is a useful illustration of how the biomedical model has been employed. The mainly male medical profession has used it in a variety of ways to 'prove' that the menopause is medically 'measurable' disease, although what has actually been diagnosed as its cause has changed amazingly over the years.

During the 19th century, Victorian physicians viewed the menopause as a sign of sin and decay McCrea (1986), presumably because it measured the ending of a bodily function that gave physiological reason to female sexual activity. Some decades later, Freud saw the menopause as neurosis, the complaints of women at this time being viewed as and abnormality die to their female psychology for which they were held to blame. Now we have the menopause as a deficiency disease with measurably lowered hormonal levels. So here we have three totally different views, all in their time given great credibility and profoundly affecting the lives of women.

Although there are many other health care professions in addition to medicine, they have few of the advantages held by the medical profession. At the top of the power hierarchy are senior doctors who achieved their dominant position by virtue of being regarding as having expert knowledge as well as holding sociolegal responsibility for patients (Freidson, 1975; cited in Bond & Bond, 2000). This is still the case in the 2000s, at a time when general managers in heath care organisations are responsible for the efficient running of the health service. The work of other professional staff organised by doctors' orders. Thus other staff may be regarded as doctors' agents in dealing with patients. While remedial therapists, social workers, can claim to professional expertise they tend to be 'staff' rather than 'line' personnel and so lack the authority awarded to doctors (Katz, 1969; cited in Bond & Bond, 2000). Nurses are even more lacking in autonomy. While acting as the representative of the doctor, they are reluctant to give care based on their own initiative or to assume personal accountability. Doctors have not only had the advantage of holding the position of power before any other health care arrived to join them, they have enjoyed a unique status in society. Many members of society have traditionally held doctors in awe because they possessed a special knowledge that set them apart.

The primary health care approach is part of a revolution in health care which put more value of lay care, and control of factors outside medicine, to improve people's health (Walt, 1994). Their technical expertise gives them particular responsibility for supporting local community and national health development programmes.

In the next lecture we will look at ways in which nurses as a professional group exercise power over consumers of health care.

ECONOMIC POWER

There are a number of economic power groups whose activities may affect our ideas of health and illness. These include those who provide private health care and those whose products are used in both private and state sectors. For example, several years ago, the ideal of having a breast reduction was virtually unknown among the general population in UK and many women suffered great discomfort. While breast reduction was possible within the state system it was limited to a very small number of women and consequently there was very little public awareness. It is only since increased private health care has enabled women to undergo this surgery. This applies to other cosmetic surgery, where it is provided by the state in exceptional circumstances such as when required as a result of burns or trauma (BMJ, 1993).

Drugs are another example where financial considerations have affected public perceptions of health care, not just in knowing that they are available but also in making choices between them and other forms of treatment. Drugs have become a mainstay of health care. This was not always so, and it is only in the past 20years or so that we have has so many drugs to treat illness.

Where does money come from to develop new drugs? Some of it is given in the form or research grants, but mainly drug firms themselves who plough back profits from drugs they are already producing provide it. An example is the HRT.

Advertising and publicity are used to increase public and professional awareness of the availability and claimed benefits of drugs just as they are for other products. Advertisers spend thousands of pounds to increase sales of their products with great success. If advertising succeeds in persuading us to buy things it seems reasonable to suppose it succeeds in affecting our choice of health care.

The private sector should listen more carefully to consumers, critically assess how its products can promote health and contribute to better environment. There will be increasing requests for scientific evidence in support of product benefit, and for the use of objective tools such as health impact assessments. Accordingly, private sector activities should become more comprehensive and health-focused than they are today. Further more, the private sector is a vital component of communities at both local and national levels; its support should therefore be actively sought for the development and implementation of pubic health programmes, as partners and in full recognition of its potentially crucial contribution.

REPRESENTATIONAL POWER

Political power, professional power and economic power all contribute to what society generally, and each of us as individuals, sees ‘health’ and 'illness’. The influence of each of these groups helps subconsciously, and often consciously to form our values and therefore to affect the demands we make for health care.

A very important type of power group is when groups of people join together specifically to represent a certain point of view or the needs of a particular group of people. For example a group of persons with disability, or sufferers from a particular disease such as AIDS, or a group of women, may form a pressure group to try to influence policy directly related to them. Such ***consumer groups*** can play an important role in health care, and have a particular significance for us as nurses.

As nurses we are in a particular position to exert influence ourselves, both as a professional group and as individuals.

In the next lecture we shall look at professionals and consumers.

References and Bibliography

Armstrong, D. (1994). ***Outline of Sociology as applied to Medicine*** (4th ed.). Oxford: Butterworth-Heinemann.

Bond, J. & Bond, S. (2000). ***Sociology and Health Care*** (2nd ed.). London: Churchill Livingstone.

British Medical Association (1993). ***Rationing in Action***. London: BMJ Publishing.

Dahl, R. (1961). ***Who Governs?*** New Haven: Yale University Press.

Department of Health. (1991). ***The Patient's Charter***. London: HMSO.

Ham, C.J. (1977). ***Power, patients and pluralism***. In: Barnard, K., Lee K. Conflicts in the National Health Service. London: Croom Helm.

McCrea, F. B. (1984). ***The politics of menopause: The 'discovery' of a deficiency disease***. In: Conrad, P., Kern, R. (eds). The Sociology of Health and Illness. New York: St. Martin's Press.

Naidoo, J. & Wills, J. (1994). ***Health Promotion: Foundations for* Practice**. London: Bailliere Tindall.

Owen, D. (1976). ***In Sickness and in Health***. London: Quarter Books Ltd.

St. Luke's Hospital, Malta (2001). Patient's Charter [On-line]. Available at http://www.slh.gov.mt/Charter. Accessed on 21 April 2003.

Walt, G. (1994). ***Health Policy: An introduction to Process and Power***. London: Zed Books.

WHO, Regional Office for Europe. (1986). ***Targets for health for all***. Copenhagen: WHO

WHO, Regional Office for Europe. (1999). ***Health21: The health for all policy framework for the WHO European Region***. Copenhagen: WHO.