Social justice in health globally

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This is a revised version of a valedictory lecture by Gavin Mooney when he left Curtin University to take up a new position at the University of Sydney. (Gavin is remaining in Perth.) The lecture looked at health and health care both locally and globally. The ‘local’ has been published by the WA Policy Forum (Mooney 2008). This paper deals primarily with the ‘global’.

Dedication
The lecture was dedicated to the memory of my parents who taught me about and to care about social justice.

Introduction
An examination of health and health care, whether locally or globally, shows that there has been little progress in the last several decades in advancing social justice. Where I remain optimistic however is in the fact that in the six citizens’ juries (involving randomly selected citizens from the voters’ roll, briefing them well and asking them as a group to reflect as citizens on what they want from the health care system) I have facilitated in Australia, all have been concerned to improve equity and all have voted for more resources for Aboriginal health. The problem is that the power to change or more accurately to block change rests elsewhere and not with the people as citizens.

It seems that in considering health policy not just in Australia but worldwide there is a great tendency to forget the poor and other disadvantaged groups. Yet we know from the work of Wilkinson (2005) and others that not just poverty but also inequality is bad for our health. We also need to recognise the importance of class with respect to health as Wilkinson and Pickett (2006) identify.

Class is often thought of as an outmoded concept in modern political discourse and this would certainly seem to be largely true in Australia; but I have to wonder. How would one describe Dalkeith and Balga and the differences between them other than in class terms? How many middle class kids now go to state schools in Perth? How many working class kids get to university? I do not know the precise answers to these questions but that matters little for the moment. My point is rather that I do not think we can begin to analyse or explain political and social life today without some sort of class analysis and without the use of the language of class.

There is also what is perhaps best described as an ‘underclass’ with respect to health care. This phenomenon exists in many countries. In Australia they are the people who turn up at emergency departments and ‘make a nuisance of themselves’ - because they have nowhere else to go. The underclass look for bulk billing GPs – and increasingly get frustrated in WA in not being able to find one. The health care underclass is overrepresented among elderly and disabled people. They risk being disenfranchised from the system. The underclass are again over represented in the mentally ill and those caught in the despair of drug addiction. Who in their right mind would approach the chaos that is the public mental health services in this state? That is not the fault of the mentally ill; nor is it the fault of the highly dedicated staff who work in these services. They are indescribably under-resourced.
No, the fault would seem to lie with all of us as citizens, as a community in that we simply do not care enough. Yet is this true? Many surveys show that we are willing to pay more taxes for example for health services, for more and better health care for the population (Leigh 2006). Yet governments continue to offer us tax cuts.

This attempt at reducing taxes, of seeking smaller government, of leaving people to stand on their own two feet is part of the belief system that goes with the ideology of neoliberalism. This Harvey (2005 p2) defines as

“a theory of political economic practices that proposes that human well-being can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterized by strong private property rights, free markets and free trade … State interventions in markets … must be kept to a bare minimum”.

This is the form of capitalism that has been around for the last 30 years.

One of the problems is that we do not have equal voices in this supposed democracy of ours. We all have a vote – a compulsory vote – but that does not make this a democracy except of the very thinnest variety. Where is the protection of minorities that a thicker democracy requires? Is Iraq a democracy just because the Iraqi people were allowed to vote?

In recent years my scribblings have been liberally sprinkled with thoughts about and appeals for greater compassion – especially public or social compassion. These have been heavily influenced by the work of Martha Nussbaum (2001) the US philosopher. Yet what is it about politicians that they assume that we want to walk by on the other side? Why do they assume we are lacking in compassion? Social compassion is important to many of us but it is not enough. What is also needed is power.

Most of all, not just in health care but in society generally, there needs to be a shift in power from the rich and powerful to the poor and powered-over. Autonomy matters but in this neo liberal world autonomy tends to be seen and interpreted in terms of the individual and individual freedom to choose – in the market place.

The question of autonomy in the community of the poor and disadvantaged and in the community on behalf of the poor and disadvantaged is a topic that has been much written about historically although less it seems in modern times.

In preparing the lecture on which this paper is based I remembered distantly a scene painted by George Orwell (1937 p16) in his Road to Wigan Pier. The last time I read it was perhaps 40 years ago but I believe it was worth digging up again. As Orwell started a train journey through one of England’s northern cities, he wrote:

“The train bore me away, through the monstrous scenery of slag-heaps, chimneys, piled scrap-iron, foul canals, paths of cindery mud criss-crossed by the prints of clogs. This was March, but the weather had been horribly cold and everywhere there were mounds of blackened snow. As we moved slowly through the outskirts of the town we passed row after row of little grey slum houses running at right angles to the-embankment. At the back of one of the houses a young woman was kneeling on the stones, poking a stick up the leaden waste-pipe which ran from the sink inside and which I suppose was blocked. I had time to see everything about her - her sacking apron, her clumsy clogs, her arms reddened by the cold. She looked up as the train passed, and I was almost near enough to catch her eye. She had a round pale face, the usual exhausted face of the slum girl who
is twenty-five and looks forty, thanks to miscarriages and drudgery; and it wore, for the
second in which I saw it, the most desolate, hopeless expression I have ever-seen. It
struck me then that we are mistaken when we say that’ It isn’t the same for them as it
would be for us,’ and that people bred in the slums can imagine nothing but the slums.
For what I saw in her face was not the ignorant suffering of an animal. She knew well
enough what was happening to her - understood as well as I did how dreadful a destiny it
was to be kneeling there in the bitter cold, on the slimy stones of a slum backyard, poking
a stick up a foul drain-pipe.”

We need to do more. We need more often to say: “there but for the grace of God …” And the
problems here are not unique to the poor. There are so many people who struggle to find a way
‘through the maze’ to get to health care. And where can they turn to, to get information and
advice? How can we as a society break down the barriers of lack of information and lack of
pathways and lack of access, in its fullest sense, for so many? South African colleagues (Thiede et
al 2007) have recently written about access and equity in a way that resonates with me. They
extend the idea of access from opportunity to use to freedom to use. That is a useful shift not just
philosophically but in practical policy terms. I would prefer however, to see freedom in terms of
autonomy for both the individual and the community.

I would suggest that there is an advantage in thinking of society as being built on a series of social
institutions, which is a Hegelian view and which embraces his construct of freedom for the
community and where the health care system is one of these social institutions (Muller 2003)”. In
looking at community autonomy – the freedom of a community – we go off down the road of
communitarianism where people’s identities are seen not just as being individual but as members
of a community and where the community is valued in its own right and for its own sake.

While these issues of community, of power, of institutions can be applied to the WA health service
and the Australian health service (see Mooney 2008), in this paper, as the next section indicates,
the key focus is the global one.

Social justice in health globally

I want now to look globally at social justice in health and health care although, as will be clear from
what I have said already, there is in my mind no sharp divide between the local and the global.

The first point I want to make in this context is that the issue here to me is not so much one of the
rich west versus the low and middle income countries, although I will attempt to examine that.
What seems to me to be crucial is the divide between rich and poor people. And this is not just
about money but about something wider than poverty of income and which relates to that feeling
of being in control of one’s life. The question of power and control are closely linked as Tim Marney
(2007) said in his very moving address to the Garma Festival in Arnhem Land last year. He spoke
of how “control is about power” and “control is keeping things in check”. And Marney spoke not
just as the ‘pointed headed’ Under Treasurer but as a human being struggling to understand why
his kids could have so much of a better life than Aboriginal kids.

We heard recently from the WHO Commission on the Social Determinants of Health (WHO 2008)” – these non health care factors that affect our health – nutrition, education, housing, poverty,
inequality, etc. That shows that poverty and inequality matter with respect to health. My own view
is that poverty and inequality probably account for anything up to 80% of the variations in ill health
across the globe and that if we are to be concerned about social justice in health we need to think
about how to reduce poverty and inequality.
Take South Africa (Mooney and McIntyre 2008)\textsuperscript{12}. So much of the joy and hope that came with Nelson Mandela’s walk to freedom has been washed away since 1994 in the tide of neo liberal economic policies that has swept through that country. Staggeringly, that country has not reduced its poverty at all in the last fourteen years despite high rates of economic growth. What it has done in its pursuit of the edicts of neo liberalism is increase its inequality so that now South Africa – under a black government and under the ANC, which once had claims to be egalitarian and even communist - now has the very dubious honour of being the most unequal society on the planet. Mbeki in his endeavours to show that a black man could run an economy just like any white, has done just that – indeed exactly that, in neo liberal terms.

The problems of South Africa may once have been about race. They are now and perhaps always were about power and about class.

The question of egalitarianism and the fight against inequality in health is well exemplified by the case of India. That country has overall very poor health with an average expectation of life at birth of less than 62. It remains a poor country but currently under the influence of neo liberal thinking and public policy, it is experiencing very rapid economic growth. A key question for health policy makers in India might be: how best in this time of boom might the Indian population, as a whole, experience betterment in their health status? This is the sort of question that health economists ought to be addressing but sadly there are few attempts to do so.

Relevant to this question is the experience of the Indian state of Kerala (Narayana 2007)\textsuperscript{13}. If it were possible for the rest of India to ‘invest’ in being like Kerala, this would lead to an estimated increase in years of life in India of approximately 11 billion. This is based on the simple calculation that there are 1.1 billion people in India and Kerala has an expectation of life at birth which is about 10 years higher than the rest of India.

At least part of the reason for this difference in Keralan health is historical and as such cannot be transferred to other parts of India (Narayana 2007)\textsuperscript{14}. It was, for example, the first state in the world to elect democratically a communist government. Land ownership is such that over 90% of Keralans own the land on which their home stands. Literacy among men is high compared to the rest of India (91% compared with 52%). For women the difference is yet greater: 86% and 19% respectively. But lessons can be learned from the nature of Keralan society that have had a bearing on its good health status and which may be applicable elsewhere.

For example Drèze and Sen (2002 pp 93-4) write:

“the contrast between [the two Indian states of] Uttar Pradesh [with an expectation of life at birth below the Indian average] and Kerala … points to the special importance of a particular type of public action: the political organisation of deprived sections of the society. In Kerala, informed political activism, building partly on the achievement of mass literacy, has played a crucial role in the reduction of social inequalities based on caste, gender, and (to some extent) class. Political organisation has also been important in enabling disadvantaged groups to take an active part in the general processes of economic development, public action, and social change … the concentration of political power in the hands of privileged sections of the society has contributed, perhaps more than anything else, to a severe neglect of the basic needs of disadvantaged groups.” \textsuperscript{15}
This emphasis on public participation as the road to population health is again stressed in by Sen (1999) in his *Development as Freedom*. He writes (p 288):

"the general enhancement of political and civil freedoms is central to the process of development itself. The relevant freedoms include the liberty of acting as citizens who matter and whose voices count, rather than living as well-fed, well-clothed and well-entertained vassals. The instrumental role of democracy and human rights, important as it undoubtedly is, has to be distinguished from its constitutive importance."  

Kerala is not however unique in doing relatively well in population health despite severely limited resources. Cuba is another example.

What are we to make of all of this? de Pinho (2005 p7) suggests that there is a need “to create a health system that encourages, supports and sustains increasing inclusion”, manifesting itself in terms of “redistribution”. She argues that:

“In marketized health systems, exclusion of those who cannot pay, is deemed legitimate. Cross subsidisation within these health systems is exposed and driven out, and any redistribution that may occur is regarded as an ‘unrequited gift from rich to poor’ which no matter how desirable in principle, if seen in these terms, will in practice be difficult to gain support for especially from the rich”.

There is, as de Pinho (2005 p 7) advocates, a need “to shift the perception and mindset regarding health systems from the prevailing conventional approach that is intrinsically market driven, towards one that is based on two fundamental principles: human rights and equity.”

The need for the poor to be organised was recognised by the philosopher Hegel lest they be left as isolated powerless individuals. He wrote:

“It is of the utmost importance that the masses should be organized, because only [by] so doing do they become mighty and powerful. Otherwise they are nothing but a heap, an aggregate of atomic units. Only when the particular associations are organized members of the state are they possessed of legitimate power.” (Quoted in Avineri 1992 p 166.)

If the poor are not organised into some communal grouping, thereby giving themselves power, as individuals they will lose their autonomy. Community autonomy for the poor, but also for societies in general matters. It is best achieved through institutionalising it.

We need compassion and a shift of power globally. Evidence that the rich nations appear not to care about the poor is provided by the fact that the UN target of 0.7% of GNP for donor countries giving aid to the developing world is met by few (Development Initiatives 2005). The average is considerably below this (0.2%-0.4%) with only five OECD countries above 0.7% (three of which are Scandinavian) and Italy and the US bottom of the ladder on 0.15% and 0.16% respectively. Australia is well down (0.25%).

Again, in its Commission on Macroeconomics of Health (CMH), WHO did too little to seek to disturb the existing political economy of world development. The Commission (WHO 2001 p 23) commented as follows on the
“many reasons for the increased burden of disease on the poor. First, the poor are much more susceptible to disease because of lack of access to clean water and sanitation, safe housing, medical care, information about preventative behaviors, and adequate nutrition. Second, the poor are much less likely to seek medical care even when it is urgently needed … Third … out of pocket outlays for serious illness can push them into a poverty trap from which they do not recover … ”.  

All of that is true but it is a description of the problems not an analysis. It does not address the global political economy that creates these situations. It is a seemingly ideologically neutral stance. In practice, in not mounting a critique of the status quo, WHO becomes a part of that status quo. The key recommendation of the report of the Commission (WHO 2001 p 4) was that “the world’s low- and middle-income countries, in partnership with high-income countries, should scale up the access of the world’s poor to essential services”. More health care is seemingly the answer and appealing to the governments of the high-income countries to fund it is the vehicle to bring health to the world’s poor. Such appeals have fallen on deaf ears before. Unless they are backed by some good analytical evidence and address the power and class structures arising through neo liberalism in individual countries and unless they are promoted internationally by global institutions nothing will change.

The CMH, as Katz (2007 p381) confirms, was “deeply conservative and unoriginal”. She argues:

“The report encourages medico-technical solutions to public health problems; it ignores macroeconomic determinants and other root causes of both poor health and poverty; it reverses public health logic and history; its is based on a set of flawed assumptions; and it reflects one particular economic perspective to the exclusion of all others … It faithfully reproduces conventional ‘free’ market, ‘free’ trade prescriptions that have been so resoundingly successful in accelerating poverty and social inequality – and in turn poor health status of populations - over the last 20 years”.  

Our global institutions do not reflect the voices of people globally. They do not in any sense represent world authority. They are dominated by the US and other large western countries and in turn by their neo liberal ideology. These countries envisage social policy, including health policy, in residual terms. The global institution of WHO remains unprepared to challenge neo liberalism.

The neo liberal west see global institutions in the image of their own national institutions and are prepared to impose where necessary (in their opinion) institutions which are foreign to the local cultures. Those institutions that have been deemed to work in country X and country Y are deemed to be suitable for country Z, as Narayana (2007) in Kerala in India shows all too well.

The question of respecting and often of maintaining local institutions – not inflexibly but relying on local values and listening to local values – is critical. As Narayan et al (2000) argue:

“despite the global efforts to create institutions that serve the poor, many of these institutions created by outsiders—whether from the state, civil society, the private sector, or international organizations—often do not have the character poor people value. Only when all these institutions embody the characteristics laid out by poor people will they make a sustained difference, a difference that matters in poor people’s lives. Poor people want institutions they can participate in and that they can trust to be relevant, to care and to listen.”

Conclusion

In conclusion, what is worth stressing is that the gaps across the globe in incomes and wealth and in turn in health are enormous. There are many statistics to show this. Just one:

The richest 2% of adults in the world own more than half global wealth. The bottom 50% own barely 1% (WIDER 2006).

We need to think about rebuilding our global institutions given the neo liberal failures that we have seen of late.

Is it not fascinating that governments can find zillions of dollars - amounting to sometimes one and a half per cent of national income – to bail out the banks. Yet over many years they can only find, in Australia’s case, a measly one third of 1% for foreign aid “to bail out” the poor of the world? We can spend zillions of dollars to get back to “business as usual” as John Stewart the Chairman of the Australian Bankers (Stewart 2008) proudly seeks to do. Business as usual is 1 billion people – a sixth of the global population – trying to survive on less than a dollar a day. It is business as usual when 35,000 children are dying each day.

We need a very different economic and social structure not the old system patched up. The old system failed. Keynes, the UK economist who was very much involved in the Bretton Woods Agreement of 1944 and which set the tone for the international economic arrangements of the last 60 years, argued for really substantial money for this – 50% of the value of world imports (Raffer and Singer 2001). What we have today is a belief that we do not need this sort of money - markets will sort things out - so that the international fund that has just failed us was running at only four per cent or one twenty fifth of what Keynes sought. Don’t be confused by these big numbers that are being banded about. They are much smaller than Keynes wanted and they are much smaller than we need today even if patching up the markets were the way to go; but I doubt it.

Where I take hope is that ‘the people’ are compassionate and I want to see much more power vested directly in citizens – here in Australia and globally. I want to see an end to governments and universities and health services getting into bed with the corporates. Faced with the threat of global warming and what that will do to inequality and poverty and global health, we need to find a new economic order and not rely on the one that created these problems.

We cannot go on being grateful to Twiggy Forrest or Rio Tinto or BHP for throwing a few crumbs from their obscenely wealthy tables at Aboriginal people. Better that than that they don’t; but it is for society to decide these social priorities and not left to the whim of Twiggy. The same is true of Bill Gates at a global level. We cannot and should not bow to his priorities.

People are or can be encouraged to be compassionate. We need to play on that and find a new social and economic order that will foster that compassion and give people more power to exercise their compassion.

It is noteworthy that in his criticisms of the neo liberal west, Joseph Stiglitz (2003 p 105), a former senior vice-president and chief economist of the World Bank and co-winner of the 2001 Nobel prize in economic science, wrote that international trade policy

“reflected the triumph of corporate interests in the United States and Europe over the broader interests of billions of people in the developing world. It was another instance in
which more weight was given to profits than to other basic values – like the environment, or life itself.”

He also endorsed the idea that people care. He states (Stiglitz 2003a):

“If the issue of access to AIDS drugs were put to a vote, in either developed or developing countries, the overwhelming majority would never support the position of the pharmaceutical companies or of the Bush administration.”

The vote of world citizenry is not called so such health issues are left to and then neglected by our global institutions. These need to be changed radically. Patching things up will not do.

Gavin Mooney is Honorary Professor of Public Health at the School of Public Health, University of Sydney. He was formerly Chair of the Social and Public Health Economics Research Group (SPHERe) at Curtin University, Western Australia and co-convenor of the WA Social Justice Network.

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