The struggle for health

This article focusses on the struggle for health from the perspective of the political economy of health. The "political economy of health" refers to those political and economic factors that influence people's health. Previously, the idea was marketed that ill health was a misfortune that scientific medicine was in a position to combat. This view is now discredited. It is clearly recognised that ill health, in both developed and underdeveloped countries, is largely a product of the social and economic organisation of society.

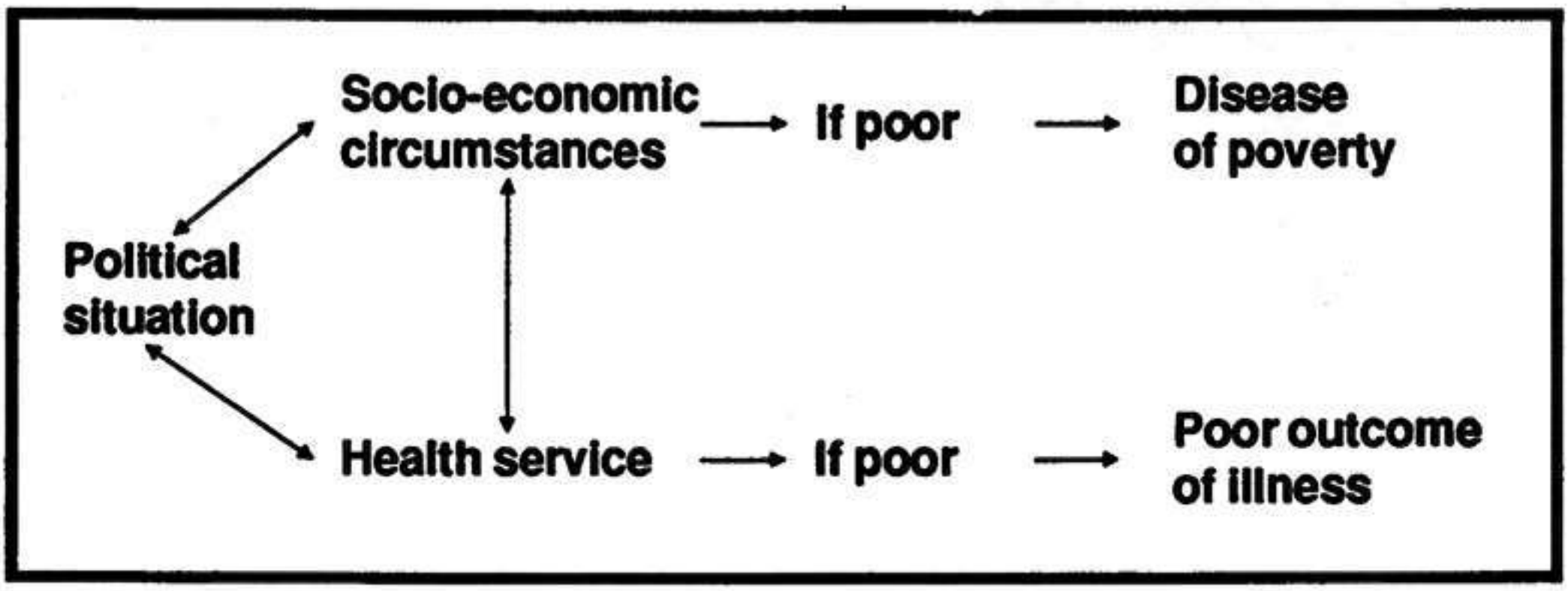
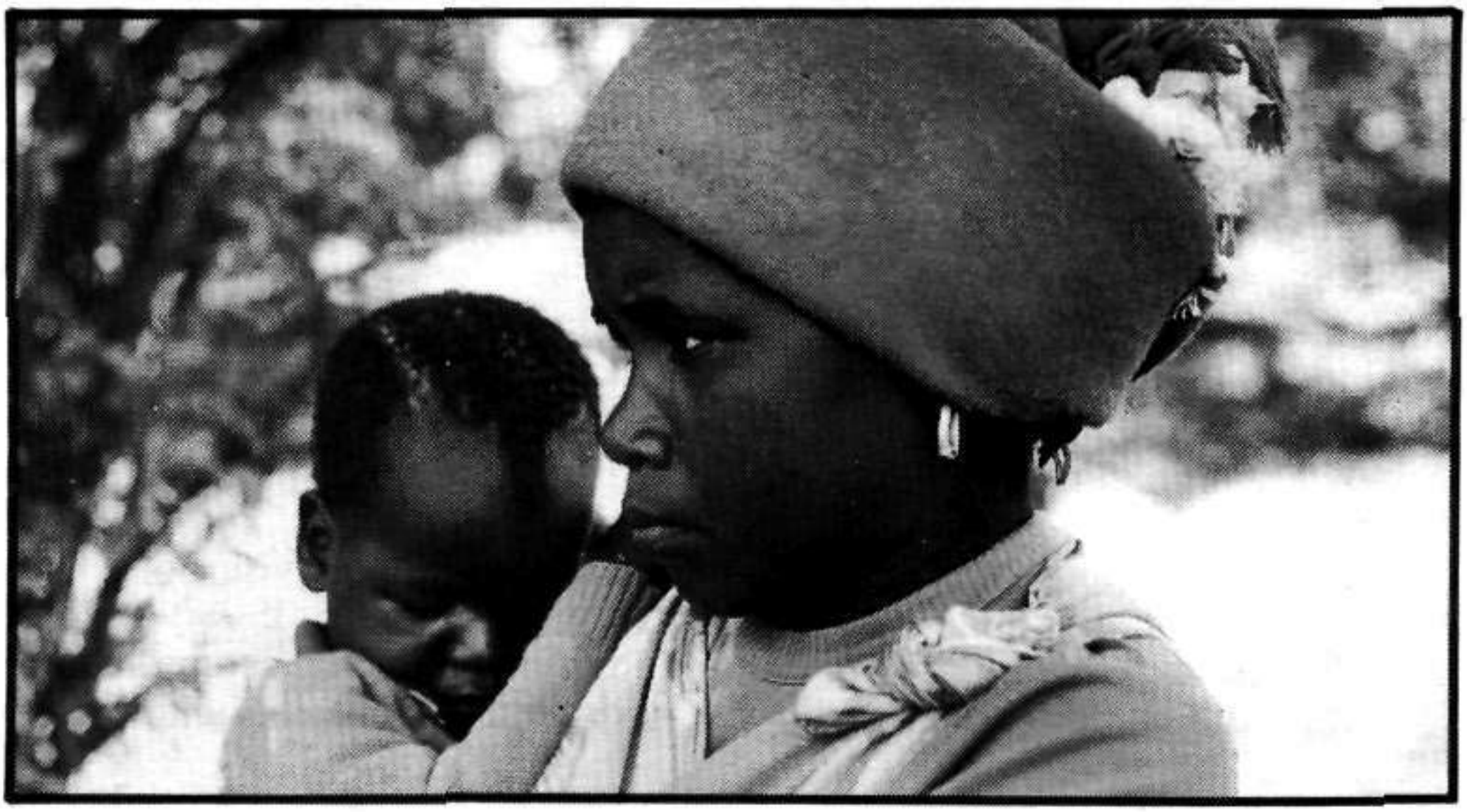


Figure 1: The political economy of health

Figure 1. depicts the political economy of health. It indicates that inadequate socio-economic circumstances lead to diseases of poverty, such as tuberculosis and typhoid, while excesses lead to the diseases of affluence, such as coronary artery disease. Socio-economic circumstance explains why people get ill in the first place, while the nature of the health service often explains the outcome of the episode of illness. Thus, because health services in the developing world are often inadequate and inappropriate, diseases that are simple to treat, such as diarrhoea and pneumonia, are killers. Needless to say, people's socio-economic circumstance and the health services they receive are themselves primarily influenced by the political situation. This applies both to world politics and the politics within countries.



Child blinded by measles: Because of inadequate health services, diseases simple to cure may become killers

In South Africa, the gross national product is large enough to drastically reduce both the prevalence of the diseases of poverty, and the often negative outcome resulting from the inadequate health services provided to many South Africans. The politics of class and racial oppression work together to block needed change, and thereby ensure that the injustices of our society are expressed in the health status of our people.

What is the end point being aimed for?

This article will focus on the health service aspect referred to in figure 1. This health service end point was well defined some 30 years ago at the Congress of the People:

"A preventive health scheme shall be run by the state;
free medical care and hospitalisation shall be provided for all,
with special care for mothers and young children." [1]

Today we recognise that the only way to meet these criteria is through a national health service that follows the progressive primary health care approach. A national health service (NHS) refers to a single, nation-wide, state-run health system, with centralised co-ordination and decentralised implementation of policy.

We need to understand that the commitment to a national health service is based not only on the grounds of social equity, but also on those of

cost-efficiency. In spite of the attempts to popularise privatisation, an NHS remains the most efficient mechanism for the use of health sector resources.

What is the nature of the struggle for health?

The struggle for health is clearly rooted in, and forms part of, the broader struggle in our society. This struggle is aiming to:

* promote discussion about, and planning of, the health service for a future South Africa;
* institute important changes now that are compatible with our vision of a future health service;
* help prepare the ground for the future transformation of the health service;
* mitigate the impact that state repression has on the health of communities.

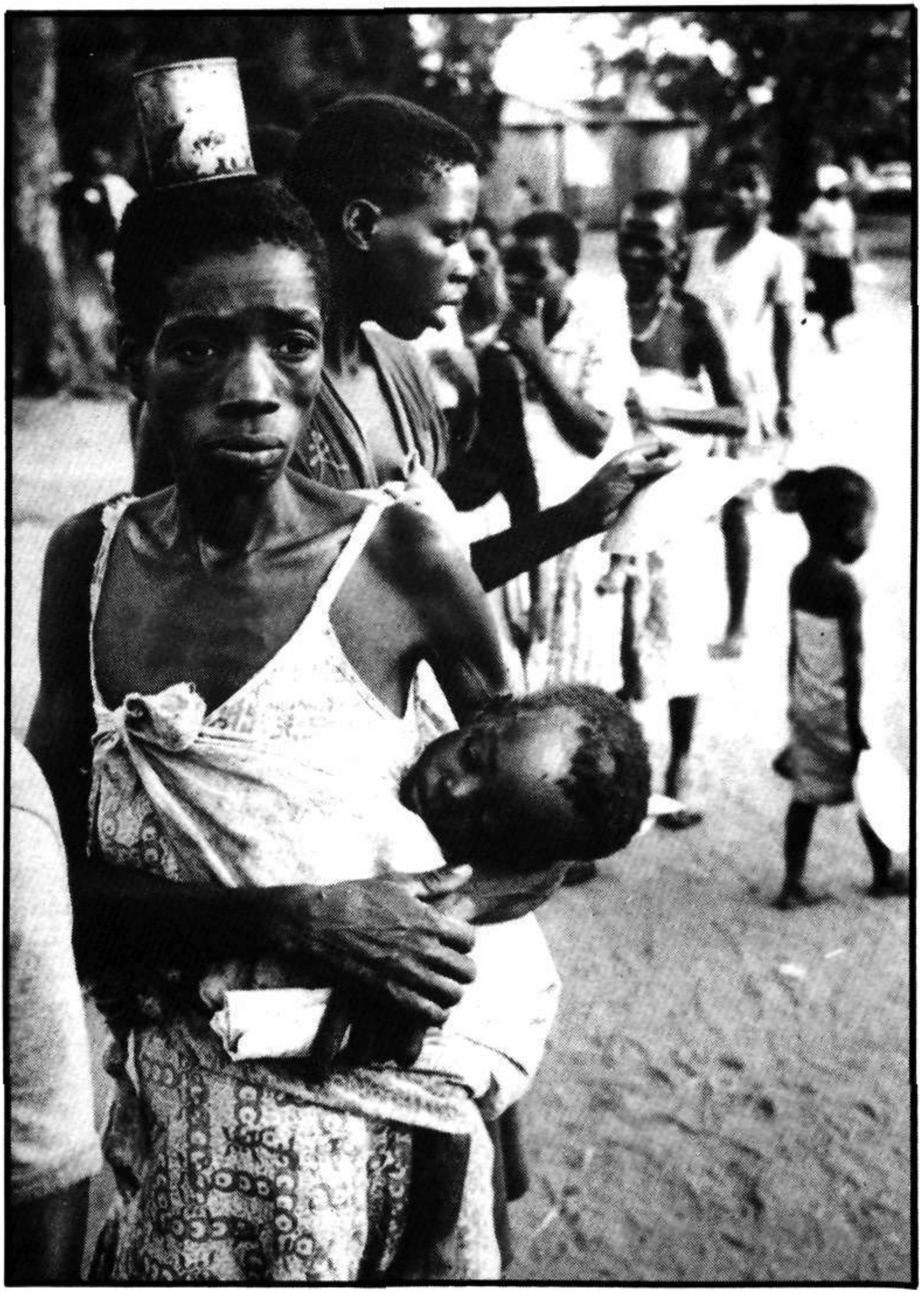
The practical expression of these objectives must take place within the framework of the broad democratic struggle. This is where the struggle for a peoples' health service will be won or lost. At the same time, we need to recognise that health and health care issues have much to offer community organisation. For example, community organisations may mobilise around, and gain credibility from, their concern with health issues. Similarly, an understanding of the political economy of health can contribute to a clearer understanding of the political economy of our society as a whole.

However, health and health service issues have not yet played their full part, either in the struggle for democracy or in the struggle for appropriate health care.

What is meant by the practice of primary health care (PHC)?

The Declaration of Alma-Ata,[2] which defined primary health care (PHC) and launched the worldwide commitment to it as the means for attaining the goal of "Health for All by the Year 2000", is essentially a political statement. There are three central elements to the definition of PHC, the attainment of which require political will and commitment.[3,4,5,6] They are:

* An attack on the socio-economic causes at the root of poverty.
* A redistribution of health sector resources to ensure equity, universal access, and the provision of essential health care to all; and to make community health care the main focus of the health service.
* The supportive and progressive practice of health care.



The injustices of our society are expressed in the health status of our people

It is important to clarify what is meant by the concept of "progressive practice". Simply working on the right sort of area, does not neccessarily mean that work is being done in the right way. The process itself is crucial.

David Werner, in a review of a number of programmes in Central America, all of which were assumed to be concerned with primary health care, suggested that the programmes fell somewhere along a continuum between the two diametrically opposing poles of being community supportive or community oppressive, where:

> "*Community supportive* programmes are those which favourably influence the long range welfare of the community, that help it stand on its own feet, that genuinely encourage responsibility, initiative, decision making and self reliance at the community level, and that build on human dignity."

In contrast, he refers to:

> "*Community oppressive* programmes which, while invariably paying lip service to the other aspects of community input are fundamentally authoritarian, paternalistic, or are carried out in such a way that they actually encourage greater dependency, servility and unquestioning acceptance of outside regulations and decisions; and those which, in the long run, are crippling to the dynamics of the community." 7

A UNICEF/WHO joint committee on health policy[4] took this understanding further by looking at the process in different socio-political circumstances. They pointed out that in politically unfavourable situations of repression and economic and social control, the state will tend to run a community oppressive health service, with excellent care for the rich and second-class care for the poor.

The services provided for the poor are then often marketed as being good services, so that with the uninformed satisfaction of the poor, the potentially explosive effects of perpetuating such inequality is neutralised.

Primary health care is therefore a process that can be practiced in a community oppressive way. This can occur if we try to force an unpopular service on people, if we behave in an elitist and arrogant fashion, or if our pattern of community participation makes lackeys of communities. We need to remember that the goals of PHC are social justice, a reorientation of health services and community empowerment.

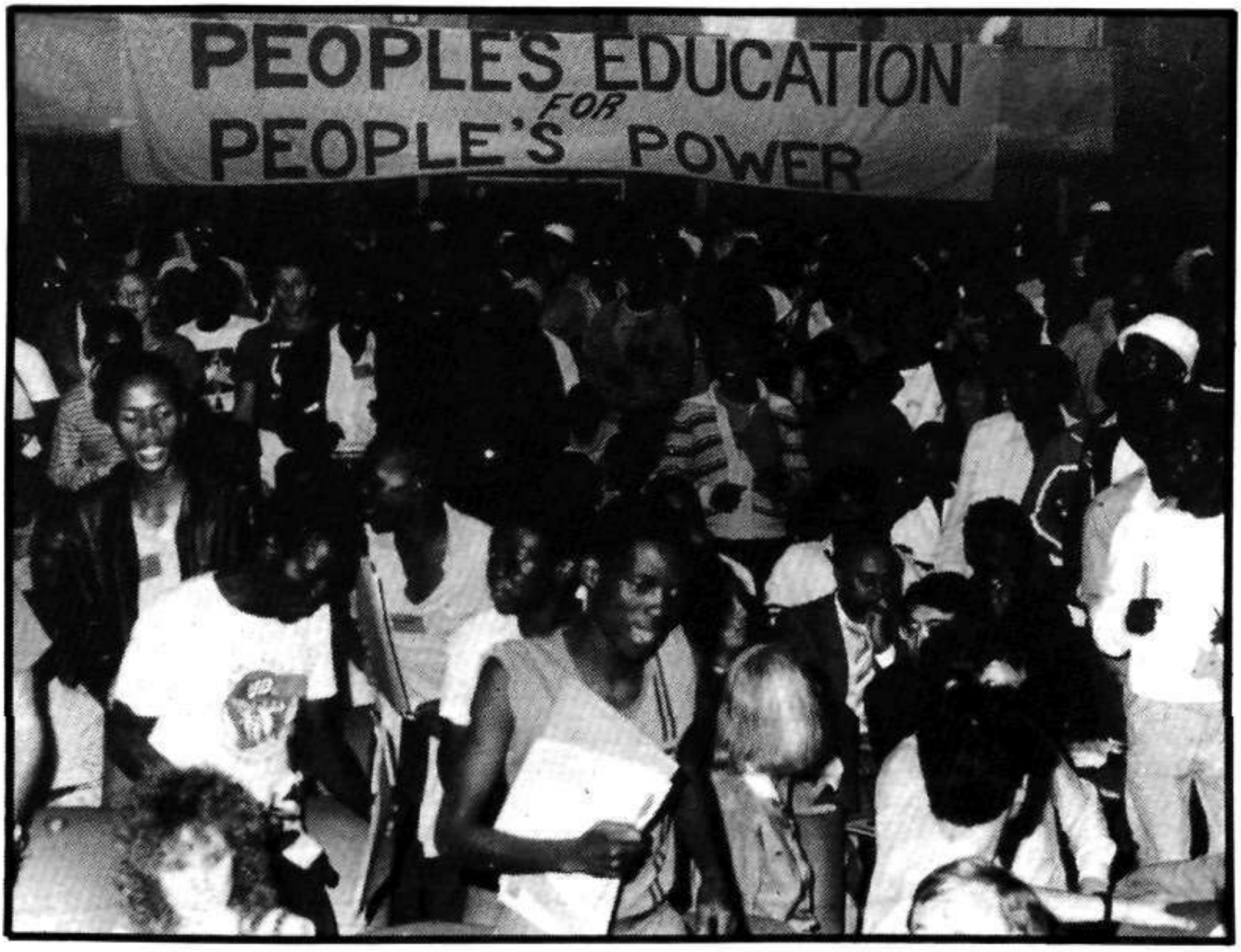
What are the threats to the struggle for health?

The major threats to the struggle for health are those factors that threaten our broader democratic struggle. However, what is not as well known are the more

specific threats to health from within the health sector. Increasing privatisation and the worsening fragmentation of health services pose the best known threats. In the future there will be difficulties in transforming the health service due to factors such as the demands of the affluent and of the health professionals.

We need to do all we can to oppose these threats, but there is another threat - the threat posed by our inadequacies as progressive health workers. As we are not always familiar with the meaning of progressive health work, we may practice in a way that contradicts our political beliefs. This may occur in the services we build, in how we interact with community organisations, in our training of health workers, or in our care of an individual patient.

Another expression of our inadequacy is that health and health care issues are not playing their full role in the democratic struggle. Communities are familiar with problems of housing and education and with potential solutions to these problems. They do not however, have the same insight and vision into their health and health care needs. Unless this happens, the health service that emerges will never become a true national health service based on the primary health care approach. This must surely be the biggest threat in the struggle for health.



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Conclusion

What has been discussed in this paper is background and philosophy. It will only be of help if the concepts are translated into concrete plans of action and implemented successfully. We all have an idea of what needs to be done, the urgency is to make it all happen in practice.

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This is a shortened version of a paper delivered at a health care workshop, October 1987 by Eric Buch, Centre for the Study of Health Policy.