Exclusionary Processes and Vulnerable Spaces: addressing the fundamental drivers of health inequalities

Belfast Healthy Cities Lecture 2
8th November 2012

Jennie Popay
Professor Sociology and Public Health
Lancaster University
UK

The Contours of Exclusion and Vulnerability

Disabled people: one in five (18%) individuals in private households in NI has some form of disability (21% for adults and 6% of children)

Irregular migrants: Citizens of Nowhere... amongst the world's poorest and the most disenfranchised.

Travelers and indigenous people: 350 + million indigenous people globally experience racism and oppression, their cultures devalued and undermined.

In NI a recent increase in **homeless people** leading to higher levels of social exclusion,

LANCASTER UNIVERSITY

Dominant Definition
States of Exclusion and Vulnerability

States of Being experienced by groups of people e.g. Indigenous peoples, extremely poor, migrants, displaced people, people with mental health problems, etc...

These groups are **excluded** from adequate living standards, decent homes, credit, health care, education, political rights, dignity, family life, etc.....

They are therefore **vulnerable** to 'shocks' and chronic impoverishment

LANCASTER UNIVERSITY

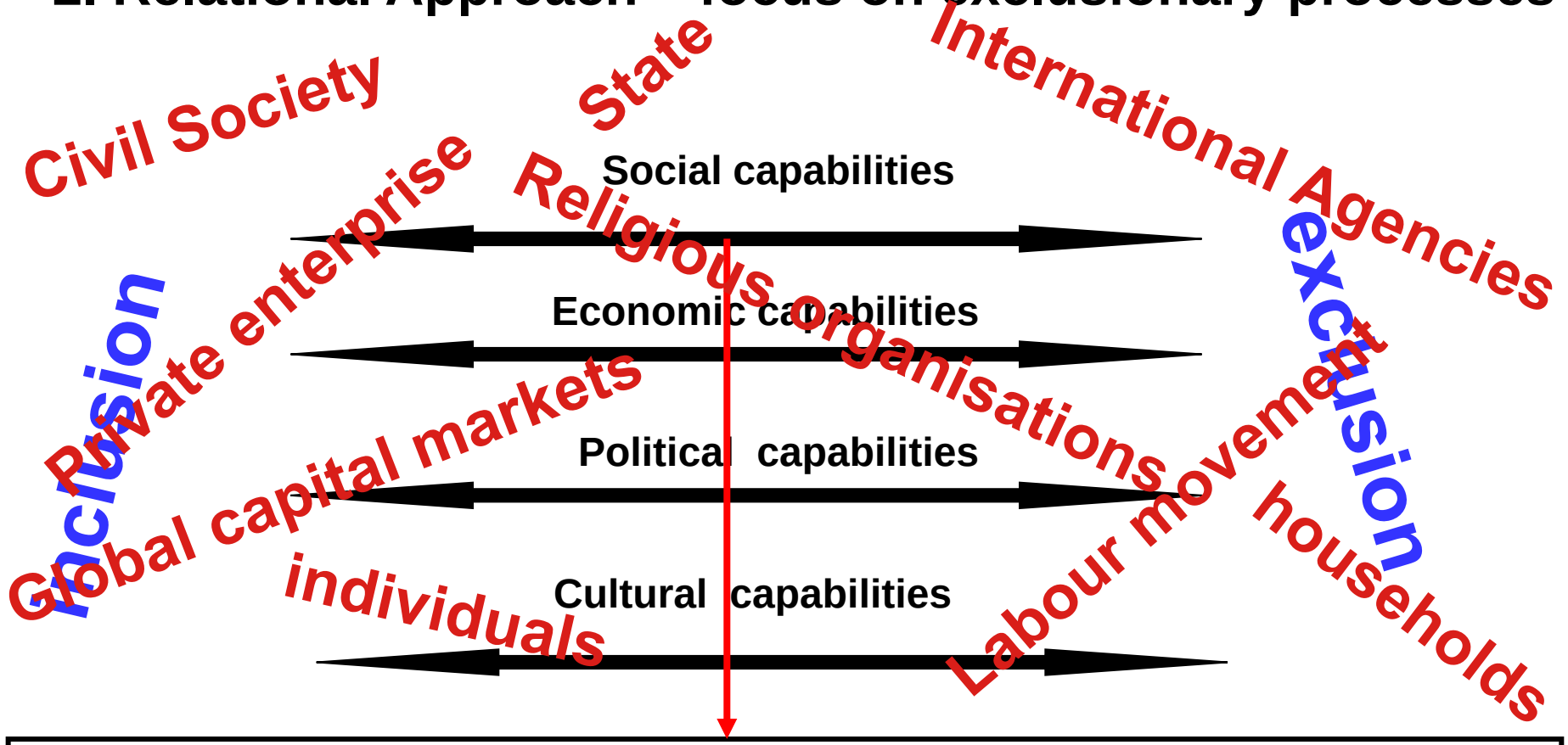
Alternative definitions
Exclusion as process and relational

- Exclusion conceptualized as dynamic, multi-dimensional processes driven by unequal power relationships

- These processes operate and interact:
  - across four dimensions - *economic, political, social and cultural*
  - at different levels: individual, household, group, community, city, national, global levels.

- Create a continuum of inclusion/exclusion characterized by *unequal access to resources, capabilities and rights*

2. Relational Approach – focus on exclusionary processes



Social positions & social stratification at different levels: individual, group, area, nation, international 'community'

Social and Health Inequities

Vulnerability as spatial and relational

- Vulnerability is a characteristic of spaces not people
- These spaces are created, perpetuated and exacerbated by those in safer more affluent spaces
- People living in these spaces develop coping strategies drawing on their capabilities and knowledge
- These coping strategies are logical in their context

Meanings drive action...

1. States of exclusion and vulnerability:
focus on levels and types of disadvantage emphasises action to reduce the GAP between specified groups and the rest of society by improving living conditions of the poor/disadvantages

2. Exclusionary processes and vulnerable spaces
focuses on drivers of inequality emphasises action to reduce the 'GRADIENT' by redistributing power across society

Greater health equity requires greater social justice

BUT HOW IS THAT TO BE DONE?

"The challenge is to work out the precise demands of social justice that are....practically useful.

Amartya Sen 2010

- Behavioural and health outcomes do not provide an ethical or sustainable basis for policies promoting social justice

- A better approach is to prioritises
  - Human flourishing as the aim of policy and practice
  - **Capability release** and development as the means.

- In this framework social justice requires policies that:
  - support the **release** & development of individual/collective capabilities
  - Remove barriers to people's ability to exercise their reasoned agency
  - Make wise use of limited resources – are effective

LANCASTER UNIVERSITY

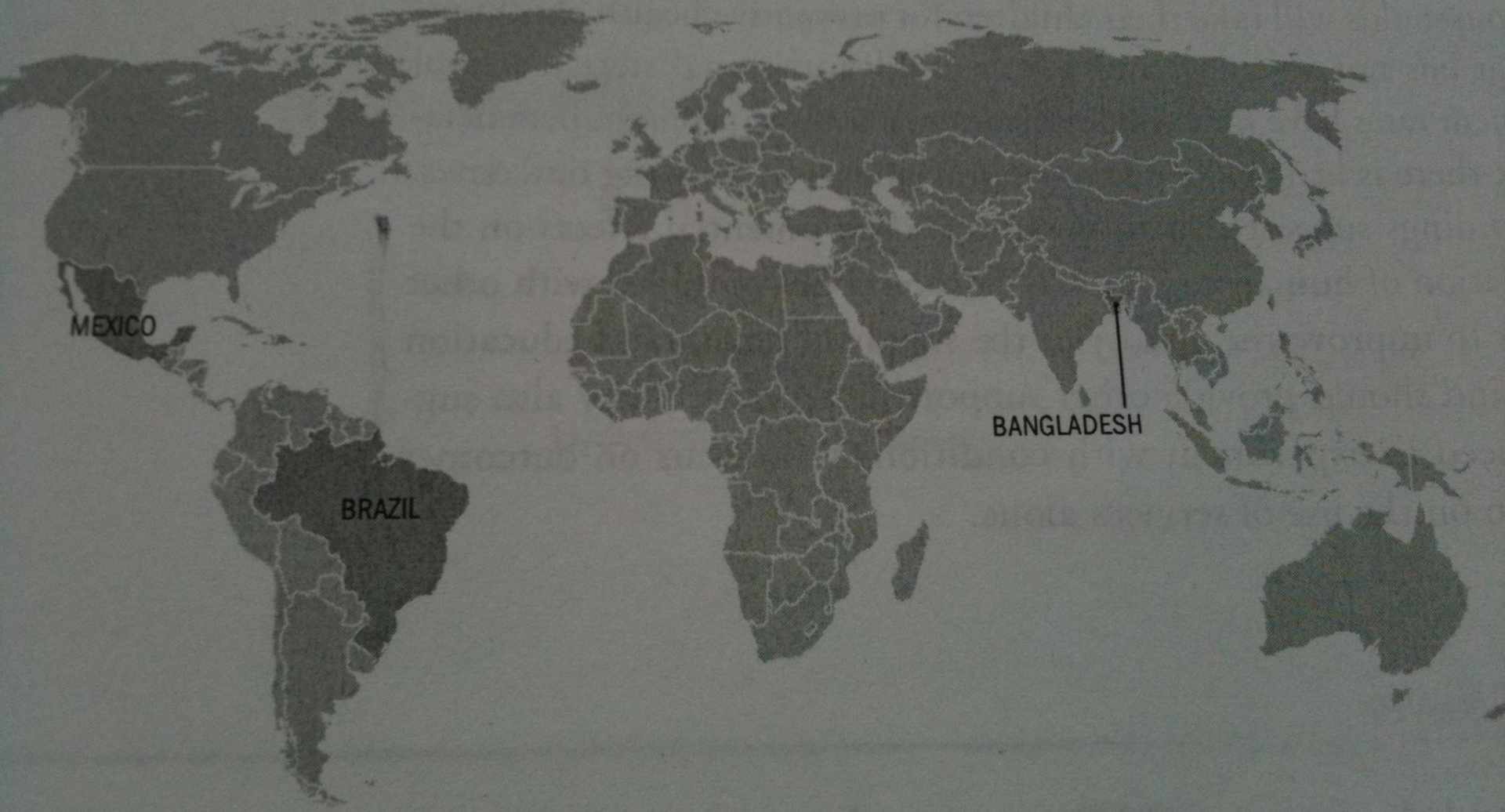
How can individual/collective capabilities be released?

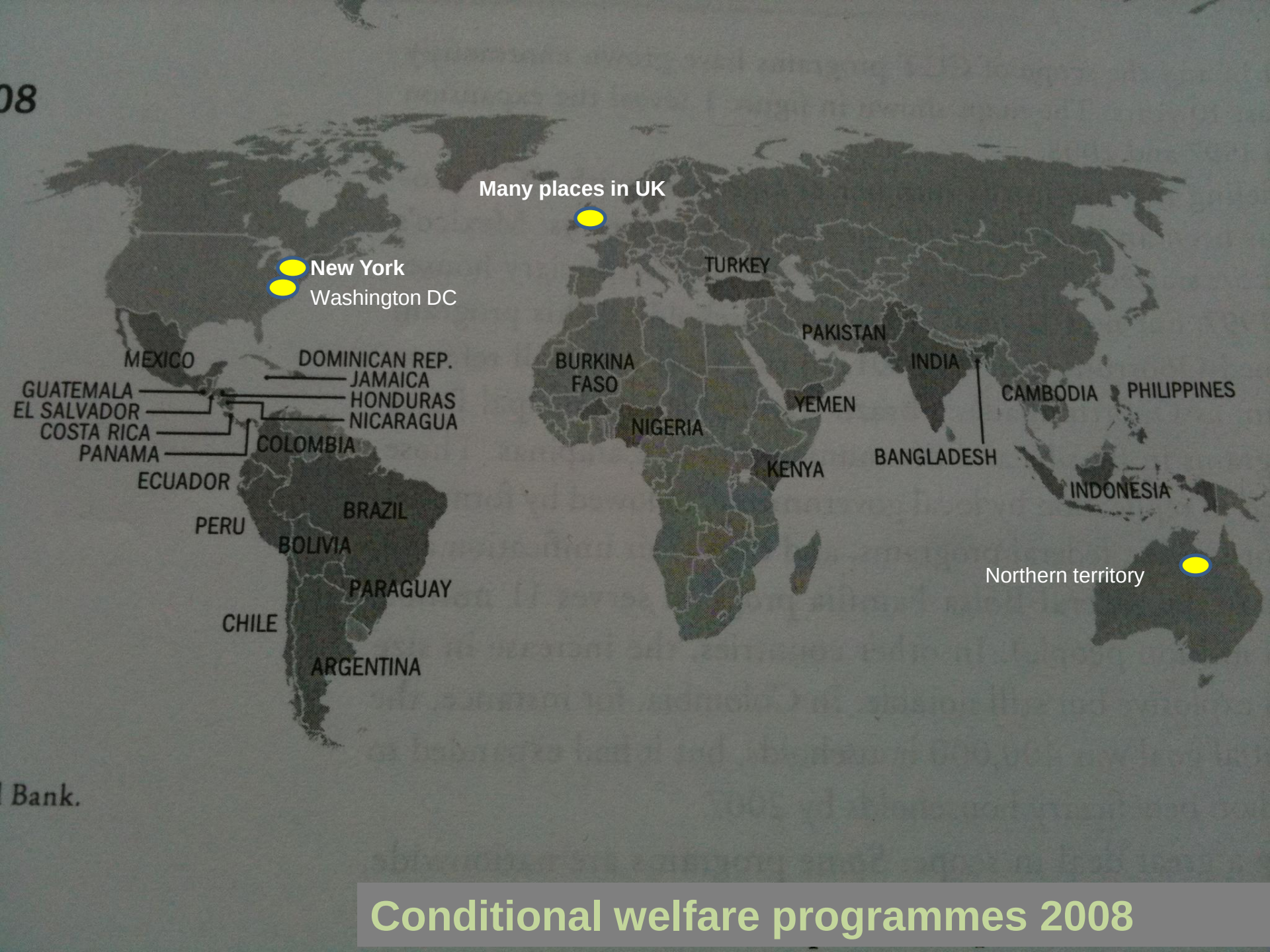
Means testing and conditionality
or
Cohesion and Participation

- 1st wave Conditional Cash Transfers programmes:
  - low &middle income countries poverty reduction strategy
  - Transfers to mothers in poor households on the condition they invest in the human capital of their children
  - Conditions required include e.g.
    - Attendance at antenatal clinics and/or parenting classes
    - Monitoring of children's development and immunisation
    - Enrolling children in school and ensuring attendance

- 2nd wave: Rapid spread and increasing diversity with cash transfers or services being provided in return for behaviour change

Conditional welfare 1997





Conditional welfare programmes 2008

Clinic Attendance			
Clinic Attendance			
Low-income pregnant women, US	Antenatal clinic	$5 gift certificate and entry into $100 raffle	
Middle-income patients, US	Return appointments	Free or reduced cost appointment	
African-Americans with depression, US	Attend appointments	$10 per appointment	
Medication adherence			
Active drug users, US	Return appointment for tuberculosis test results	$5 or $10	
Homeless patients, US	Return appointment for tuberculosis treatment	$5	
Low-income patients	Take-up flu and childhood immunisation	Lottery for groceryvouchers of $50 or $25 to $100	
Low-income women	Enrol in mammography screening	$10 incentive if enrolled within a year	
Tuberculosis	Regular	$5 grocery coupon	
Smoking cessation			
Employees	Smoking cessation	Salary bonus for not smoking at work	
Employees	Smoking cessation and weight loss	money withheld from paycheck returned if goal met	
Diet			
Overweight adults, US	Weight loss	Free pre-packaged meals or financial incentive max $25 week.	
31 obese people	Weight loss	Deposit $200 -return $20 per week if attend meetings, met calorie restriction goal or met weight-loss goal.	
Smoking			
Smokers	Quit smoking	Quit and win lottery-style competitions	
Smokers	Quit smoking	Quit and win lottery-style competitions	
Smokers	Quit smoking	cash or holiday prizes	
Exercise			
Obese patients, US	Increase physical activity	Financial incentive of $1–$3 per walk plus personal training	
Low-income patients, UK	Increase physical activity	Motivational interviews and leisure centre vouchers	
Sexual health			
Teenage mothers, US	peer-support to prevent repeat pregnancies	$7	
STI patients, US	Attend 4 risk-counselling sessions	$15 or voucher of equivalent value	
Drug cessation			
Cocaine users, US	Abstain from drug use	Retail vouchers with therapy and living skills	
Cocaine users, US	Abstain from drug use	Retail vouchers	

Macklin Announces Massive Changes To Welfare

26 Nov 2009 “New Matilda”

http://newmatilda.com/2009/11/26/macklin-announces-massive-changes-welfare

Late on Tuesday in Canberra, while the eyes of the nation were focused on a climate split in the Coalition party room, the Minister for Families, Housing, Community Services and Indigenous Affairs, quietly briefed a few selected journalists on controversial plans to roll out **welfare quarantining** nationwide. Both the timing and manner of the release were highly suspicious. If the legislation is passed, the Minister will be able to make any area in Australia a "declared income management area". The new measures will then apply to quarantine 50 per cent of the welfare payment of income recipients in three broad categories including disengaged youth between 15 and 25-years-old and have been receiving payments for 13 out of 26 weeks..

Three key questions from a social justice perspective

- Does mean-tested and conditional welfare programmes work better than unconditional ones?

- Do they have any adverse effects?

- Are they compatible with an approach to increasing social justice that prioritising capability release and social cohesion to ?

Does targeting and conditionality work?

Conditional cash transfers have been associated with:

- Reduction in child poverty/ increase in household income
- Improved nutrition and child growth
- Increased attendance at clinics and immunisation rates
- Increased school registration and attendance
- Decrease in child Labour
- Increase hepatitis vaccination amongst intravenous drug users
- Increase uptake of TB programmes
- Increased smoking cessation rates

LANCASTER UNIVERSITY

But the picture is complicated....

- Largest impact on use of services – process indicators
- Mixed evidence of impact on 'final' outcomes e.g. more years of school but attainment not improved and wages not increased
- Less effective at changing complex behaviours e.g. smoking
- Differential impact e.g smoking cessation lower in low income groups
- Policing compliance has high administrative costs
- Experience can be stigmatising and dispiriting

And the conditions may not be necessary

- Universal child benefits in UK are associated with:
  - Reduction in child poverty
  - Women spending money on food, children's clothes & school fees
- Universal free primary education in Botswana resulted in:
  - attendance rates increasing to 84%
  - Gender parity at primary school level
- Rural Ecuador experimental unconditional cash
  - positive outcomes for physical, cognitive, and socio-emotional development of children
  - poorest children had outcomes significantly higher than comparable children in the control group

Means testing, conditionality and capability release

Economic coercion contradicts the ethical demands of social justice - freedom to choose is central to a socially just society

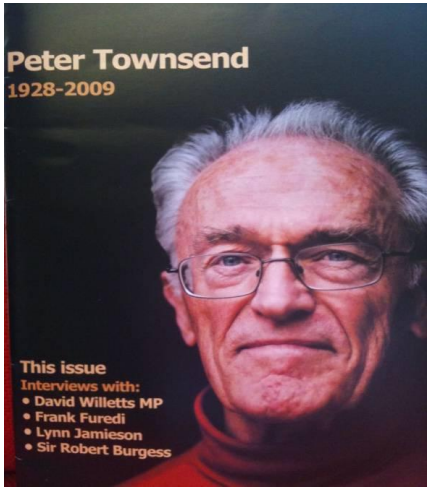
"Whilst functioning should be held in view by governments, capability is the political goal – policies must respect humans' ability for practical reasoning and choice ...once capabilities are assured people must be free to make choices" (Nussbaum)

? Impact on social cohesion?

An alternative to targeted conditional welfare?

1. Renew universalism – social protection floor
2. Empower people and communities – participation

1. Capabilities release via renewed universalism



"The task is not just to re- introduce a successful historical model. It is to re-shape that model to meet new problems as well as problems that have been familiar for generations.

The strength of a universalistic approach...is in building coalitions between groups in society....

Shrewdly interpreted, universalism can encompass rights by gender, race, ethnicity, age and disability and give nationalism a stronger edge both in negotiating with outside powers and withstanding international shocks". (Townsend, 2007, pp1)

2. Cohesion and capability release via participation & empowerment

It involves people with little power having REAL power over decisions affecting their lives

It is a human right to have control over one's destiny

It can directly improve living conditions and reduce inequalities

LANCASTER UNIVERSITY

Why should cohesion and empowerment improve health?

- Can deliver collective control of publically funded, publically provided services
- Helps build collective identity and contributes to social cohesion
- Control and cohesion – good for our health

Evidence on the impact of cohesion and participation/empowerment

- Participative systems have been shown to produce improvements in:
  - The acceptability, quality and effectiveness of local services
  - People's perceptions of the place in which they live
  - Social cohesion and social relationships in local places
  - People's subjective perception of their health
  - People's economic circumstances through enhanced skills

- But people's experience of participation too often leads to:
  - Physical and emotional health damage
  - Social isolation and guilt
  - Disillusionment and disempowerment

- Some evidence that 'genuine empowerment' can have dramatic impact on health inequalities...

The impact of cohesion and participation/empowerment on health inequalities

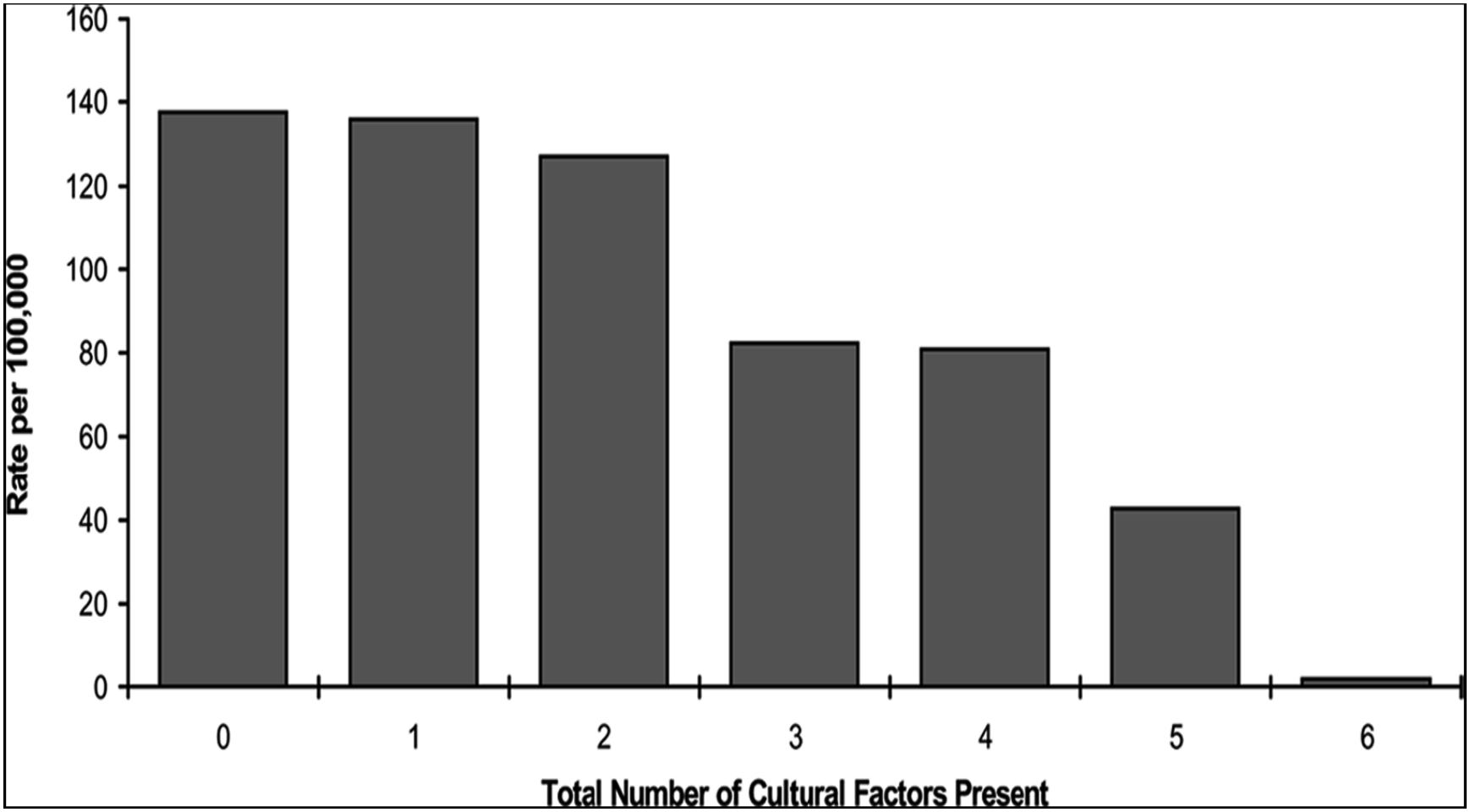
- Study of Indigenous suicide in British Columbia
  - Youth suicide five times greater than rest of population (1987-1992)
  - But not uniformly distributed across 1st Nation groups:
  - So, aboriginality *per se* is not a risk factor.

- Tested hypothesis: 'Cultural continuity' explained differences

- Measures of cultural continuity reflected degree of 'community control'
  - history and success of land claims;
  - self government;
  - control of services;
  - Dedicated cultural facilities

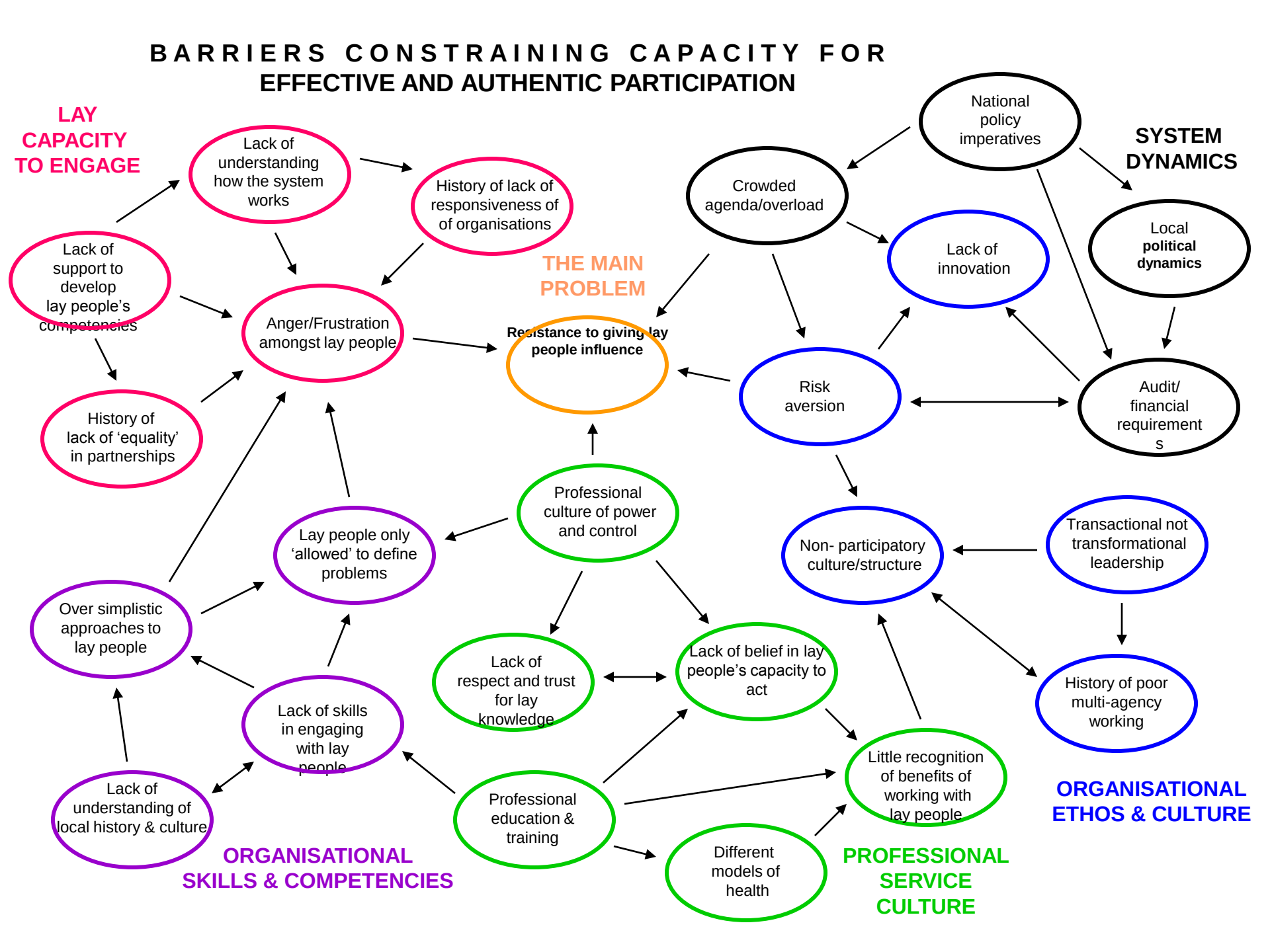
Personal persistence, identity development and suicide, Chandler, Lalonde, Sokol, Hallett, Monogr.Soc.Res.Child.Dev

Decreasing suicide rates with increasing community ‘control’



But England and NI a long way from genuine participation

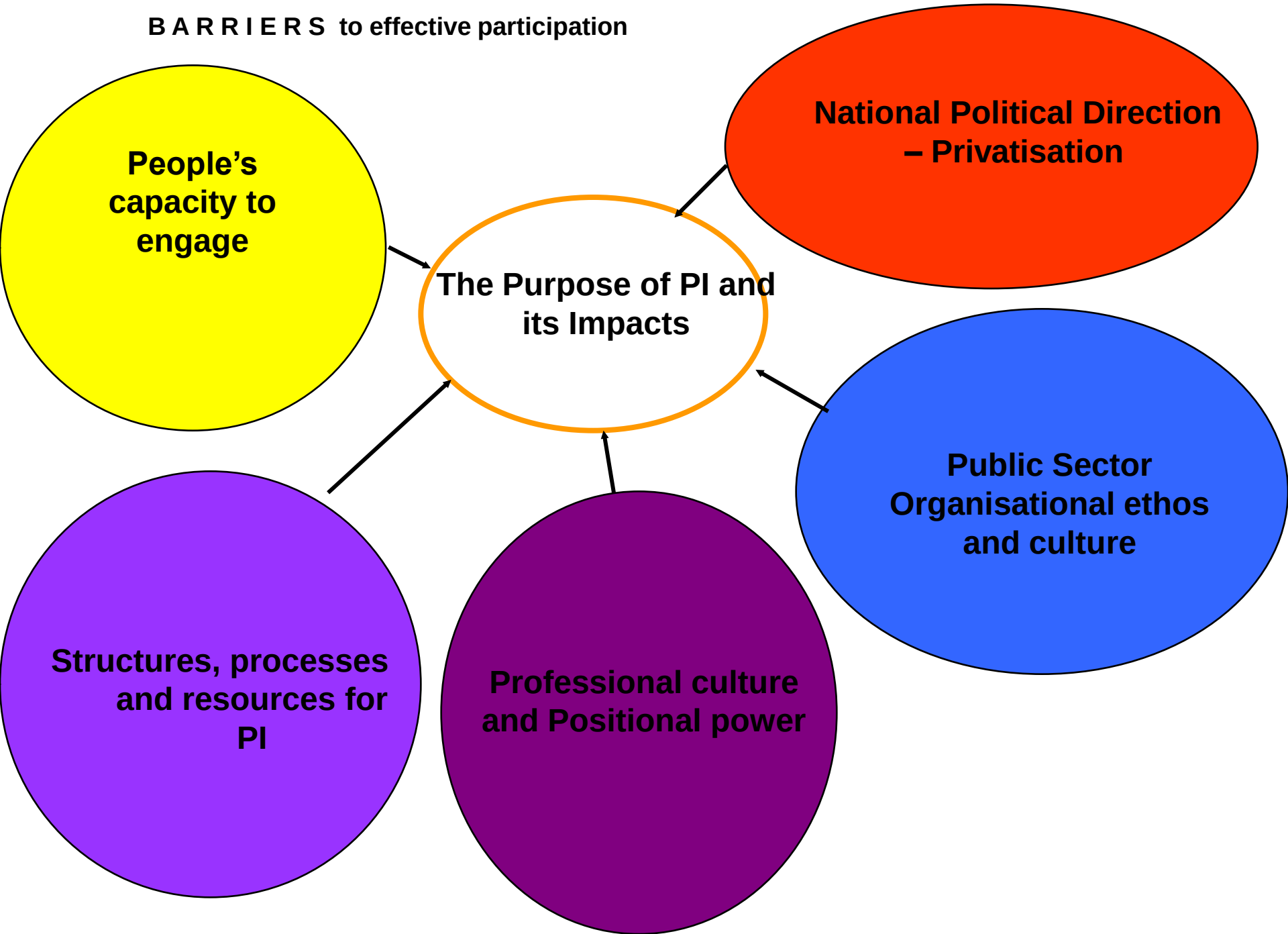
“Participation in civic and public life, reflective of our increasingly diverse population, helps facilitate a more informed policy decision-making process. Despite recognition of this, there remains persistent and considerable under-representation of many groups in public, political and civic life, resulting in further marginalisation of such groups and a range of services that do not give expression to the experiences of people in those groups. (report of equality commission in NI 2007)


BARRIERS CONSTRAINING CAPACITY FOR EFFECTIVE AND AUTHENTIC PARTICIPATION
LAY CAPACITY TO ENGAGE
Lack of understanding how the system works
History of lack of responsiveness of of organisations
Lack of support to develop lay people's competencies
Anger/Frustration amongst lay people
History of lack of 'equality' in partnerships
THE MAIN PROBLEM
Resistance to giving lay people influence
SYSTEM DYNAMICS
National policy imperatives
Crowded agenda/overload
Lack of innovation
Local political dynamics
Risk aversion
Audit/ financial requirements
Professional culture of power and control
Lay people only 'allowed' to define problems
Over simplistic approaches to lay people
Non- participatory culture/structure
Transactional not transformational leadership
Lack of respect and trust for lay knowledge
Lack of belief in lay people's capacity to act
History of poor multi-agency working
Lack of skills in engaging with lay people
Lack of understanding of local history & culture
Professional education & training
Little recognition of benefits of working with lay people
Different models of health
ORGANISATIONAL SKILLS & COMPETENCIES
PROFESSIONAL SERVICE CULTURE
ORGANISATIONAL ETHOS & CULTURE

A MESSY MODEL!

BUT REAL LIFE IS LIKE THAT!

A simpler picture looks like this.....


B A R R I E R S to effective participation
People's capacity to engage
National Political Direction – Privatisation
The Purpose of PI and its Impacts
Public Sector Organisational ethos and culture
Structures, processes and resources for PI
Professional culture and Positional power

Community participation can mean anything you want it to!

A selection of English policy statements……

- **‘empowering citizens to express views on how needs are met’.**
- **‘working with local people to strengthen accountability’**
- **‘bringing local people into the service delivery system’**
- **‘putting active citizens at the heart of tackling social problems’**
- **‘Building people’s skills, knowledge, abilities and confidence to take action and play leading roles in developing communities’**
- **Nothing about us without us! Consumers of privatised services**

Confusion over the purpose of participation/empowerment

- **For politicians: a technology of legitimacy** (Harrison and Mort)
  - To bolster support for the NHS (Labour)
  - To help manage transition to private market in care (Conservatives)
  - To water down privatisation and stay in power (Lib Dems)

- **For managers: a mechanism to improve efficiency**
  - Expert patients and self care
  - Rights with responsibilities, more responsible use of services

- **For health and social care professions**
  - sharing power and responsibility
  - Co-production of health and well being

And for citizens/people?

Health is not bought by the chemist's pill
Nor saved by the surgeon's knife
Health is not only the absence of ills
But the fight for the fullness of life
Piet Hein

Photography courtesy of Helen Roberts

Community participation is

- **Sometimes good**
  - Opening up space for individual and collective control, increased cohesion and social transformation
- **Often bad**
  - legitimising reduced role for public services with inadequate resources and little power or influence
- **But increasingly ugly**
  - Damaging the lives and health of activists
  - Supporting privatisation of public services and welfare

Need to focus on the 'real' issue: the purpose of participation and empowerment

- **It shouldn't be about consumer power**: providing information to enable people to operate in the market and redress for grievances
- **It should be about social cohesion and shared identity**: engaging people in enduring dialogues about how health is to be protected and promoted and how life is to be lived

It is always a struggle over meaning – a political dialogue