

Viewpoint

Political will for better health, a bottom-up process

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Summary

Lately, different voices in the global public health community have drawn attention to the interaction between the State and civil society in the context of reducing health inequities. A rights-based approach empowers people not only to claim their rights but also to demand accountability from the State. Lessons from history show that economic growth does not automatically have positive implications for population health. It may even be disruptive in the absence of strong stewardship and regulation by national and local public health authorities. The field research in which we have been involved over the past 20 years in the Philippines, Palestine, Cuba, and Europe confirms that organized communities and people's organizations can effectively pressure the state into action towards realizing the right to health. Class analysis, influencing power relations, and giving the State a central role have been identified as three key strategies of relevant social movements and NGOs. More interaction between academia and civil society organizations could contribute to enhance and safeguard the societal relevance of public health researches. Our own experience made us discover that social movements and public health researchers have a lot to learn from one another.

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Research has demonstrated that economic development, which has doubtlessly contributed to the improvement of the health status in high-income societies, does not automatically have positive implications for population health. Throughout history, political decisions have had a tremendous impact on population health. More often than not, these policies were a response to pressure from below by social movements. The public health historian Simon Szreter (1997) argues that economic growth may even be disruptive in the absence of strong stewardship and regulation by national and local public health authorities. With reference to the British experience, Szreter observes that '(S)ignificant health improvements only began to appear when the increasing political voice and self-organization of the growing urban masses finally made itself heard, increasingly gaining actual voting power from the late 1860s onwards (a process not completed until 1928).' As they were able to make themselves heard by the new urban elite, 'this new generation of civic leaders devised new sources of funding from the massive revenues of local utility monopolies' to launch an extensive program of investment in municipal health amenities and social services (Szreter 2003).

An analysis of the European welfare states' genesis reveals a similar role of the labour movement in putting pressure 'from below' on political leadership. This holds true for Bismarck's late 19th century pioneering social insurance as well as for Beveridge's (and others) post WWII reforms in Great Britain and other West-European countries (Baldwin 1990). In postwar France, strike waves and generalized strikes significantly influenced social benefits, the minimum wage and working hours (Borrel 2004).

Referring to the influence of the Soviet Union after World War II, Vicente Navarro (1989) observed that 'the growth of public expenditures in the health sector and the growth of universalism and coverage of health benefits that have occurred during this period are related to the strength of the labor movement in these countries'. Social-Democratic and Christian-Democratic parties have, in many instances, been the privileged political instruments for these civil society movements to channel their demands into social policies. In developing countries also, improvements in health systems and policies influencing the broader determinants of health were indicative of government's responsiveness to organized demand for policies supportive of public health. In Latin America, for example, this has been documented in situations as diverse as Brazil

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(Elias & Cohn 2003), Costa Rica (Unger *et al.* 2008), Nicaragua (Garfield & Williams 1992) or Cuba (De Vos 2005) and in varying forms and degrees.

Applying lessons from history

Lately, different voices in the global public health community have drawn attention to the interaction between the State and civil society in the context of reducing health inequities. The Commission on Social Determinants of Health (CSDH 2008) has put the issue of health equity to the fore, unveiling the need to tackle inequities of power, money and resources. The CSDH stated that 'Community or civil society action on health inequities cannot be separated from the responsibility of the state to guarantee a comprehensive set of rights and ensure the fair distribution of essential material and social goods among population groups' (Marmot *et al.* 2008). Therefore, political will of governments and 'pressure from below' by civil society organizations are perceived as essential (Blas *et al.* 2008).

Similar ideas are echoed when it comes to health care and health systems. The 2008 World Health Report critically assessed the way that health care is organized, financed, and delivered in rich and poor countries and concludes that inequities in access to care and in health outcomes are usually greatest in cases where health is treated as a commodity and care is driven by profitability. To steer health systems towards better performance, the report calls for a return to primary health care. While acknowledging that the ultimate responsibility for shaping national health systems lies with governments, the report also observes that 'demand from the communities that bear the burden of existing inequities and other concerned groups in civil society are among the most powerful motors driving universal coverage reforms and efforts to reach the unreached and the excluded'. The report highlights that local action can be the starting point for broader structural changes, if it feeds into relevant political decision and legislation. Civil society organizations are thus a necessary complement to more technocratic and top-down approaches to assessing social inequalities and defining priorities for action (WHO 2008).

Likewise, the emergence of rights-based approaches to health stresses the crucial role of the State in respecting, protecting and fulfilling the right to health. A rights-based approach empowers people not only to claim their rights but also to demand accountability from the State (Luttrell & Quiroz 2007). Civil society organizations have an important role to play to empower rights holders to assert their right to health vis-à-vis the State as the primary duty-bearer (Turiano & Smith 2008).

Experiences with empowerment for health

The action research in which we have been involved over the past 20 years confirms that pressure through organized communities and people's organizations can effectively move state institutions into action towards realizing the right to health. Summarizing some of these experiences, we identified class analysis, influencing power relations, and giving the State a central role as three key strategies of relevant social movements and NGOs (De Vos *et al.* 2009).

First, considering that communities and society are not homogeneous entities, we have learnt to give due attention to issues of social class as one of the determinants of social exclusion. We cannot neglect the fact that power relations – within communities and broader society – are intimately related to people's economic interests. We therefore hold participatory processes, which bring issues of social class to the fore, in high regard.

In the Philippines, we have been working with the non-government Community Based Health Programs (CBHPs) that learned the importance of social investigation, a thorough study of class relations within a community, to guide their interventions. Community organizing is a key strategy that benefits from this analysis to ensure due representation of marginalized groups in decision making. Wherever CBHPs were able to put these principles into practice, they ceased being only an alternative healthcare delivery system that substituted for the government's defunct system and became instead an avenue for social change (Council for Health and Development 1998). Second, we experienced that issues of power, power relations and power conflicts should be seen as the cornerstone of any involvement with social movements. Without due analysis of power relations and interests, it is impossible to work on empowerment of communities and social movements.

In Palestine, we have been working with the Union of Health Work Committees (UHC), an organization that has emerged from the many popular committees formed since the late 1970s to organize basic health services for local populations under Israeli occupation. With the advent of the Palestinian National Authority (PNA), a consequence of the 1993 Oslo Accords, massive amounts of aid arrived to build the infrastructure of the Occupied Palestinian Territories. Large international NGOs, EuropeAid and the World Bank gained influence over local Palestinian organizations, who found themselves caught in a difficult negotiation process between international funding agencies on the one hand and their own constituencies on the other, as their attention was diverted from the root causes of the conflict. Although the UHC benefited from foreign aid for the construction of its health infrastructure since 1993,

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the UHWC continued to analyse power relations and never forgot the root causes of the conflict. In recent years, the organization reformulated its strategic goals while reaffirming this orientation and it devised a new foundational principle stating that '[h]ealth work cannot be effective unless it is part of a larger social change'.

Third, there is the role of the State. Frequently in public health discourse, focus is placed on individuals and their immediate social environment. The State and its international relations are all too often kept out of the picture. As the State is shaping the health system and has the levers to influence the broader social determinants of health through other ministries, it seems mandatory to give due importance to its role.

Cuba's recent history illustrates the role that the state can play in ensuring its citizens' right to health, if the necessary political will is present. Working with government agencies in Cuba, we witnessed how their participatory approach was essential to the implementation of practical solutions during the economic crisis of the 1990s, a consequence of the Soviet Union's collapse, and how the right to health was maintained as a state priority. During the most difficult years, community organizations, trade unions and state enterprises helped, for example, to ensure that prioritized groups (pregnant women, children, and the elderly) had access to basic food and milk. At present, many links exist between local public health services and neighbourhood people's organizations. Neighbourhood and health committees work closely with local authorities and health care providers and participate in health needs analyses of their communities, in activity planning, and in preventive actions. These committees also function as a space in which people can voice their complaints about the healthcare system. Health committees can call doctors and other health workers to account and – if necessary – request that they be replaced.

In Europe

Our experience in Europe shows that advances in health policies can be reversed. Today, the European social security systems are under attack, and their deregulation and/or privatization is being debated. The degree to which social achievements will be dismantled or maintained will essentially depend on 'political will', i.e. power relations between social classes, within the individual countries and at European level. Once again, decision making will be the result of a struggle between conflicting interests, with conflicting logics and conflicting goals. A century ago, European trade unions played an essential role in abolishing child labour and achieving universal health care and social security in their countries. Today their (op)position

might dramatically influence the outcome of today's attempts to roll back these achievements (De Vos *et al.* 2004).

Interestingly, observations in Europe confirm our experiences in the South that empowering communities and groups in society is very much compatible with encouraging people to take up their own responsibilities in realizing their rights. The case of the non-governmental organization 'The Link' (<http://www.de-link.net>) in Belgium is illustrative in that respect. The strategy of this NGO is to offer people who themselves have experienced (and sometimes still do) a situation of social exclusion in their lives a training that starts from an analysis of their individual history but that eventually provides them with better understanding and insight in the structural determinants of social exclusion (Spiesschaert 2005). These people then become "experts by experience" in the fight against social exclusion and are increasingly involved – with some reluctance from the side of professional social workers – as experts in the design, implementation and evaluation of public anti-poverty policies of federal, regional and local governments in Belgium. These experts by experience are not only empowered individuals but also critical analysers of public policies designed by decision-makers often alienated from the harsh realities of social exclusion.

Medicine For The People (MFTP), a Belgian network of eleven community-based clinics, has experiences with community mobilization. For example, in 2005, the MFTP doctors in Genk detected an abnormally high prevalence of respiratory problems in patients living near to the Arcelor-Mittal steel factory. High concentrations of heavy metals in the air were suspected to be the cause. An inquiry into the patients' health confirmed the abnormally high number of respiratory problems. With help of MFTP, the inhabitants started a petition against the pollution and organized a well-attended children's demonstration around the factory site. These actions generated elaborate media attention. Eventually, the municipal authorities decided to move the elementary school from the hot spot zone to a healthier area and popular mobilization and media attention forced the regional government to start up a general health survey and inform the population of its results. Moreover, the renovation and insulation of a number of social residences in the area moved to the top of the agenda.

Implications for health research

Our own field experience in different countries – in Belgium and overseas – supports the hypothesis that civil society organizations and social movements (still) have an important role to play. Next to their potential to enhance

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social inclusion, they can help people to assert their right to health, act as a platform to voice people's demands and needs, and pressurize public authorities to effectively implement the social policies needed to improve health and health care. In short, experiences in different countries and circumstances show that, if marginalized groups organize, they can influence power relations and 'trigger' (or hammer) the State's political will into action. Popular pressure through organized communities and social movements can play an essential role in ensuring the implementation of adequate government policies to address health inequities and realize the right to health.

More interaction between academia and civil society organizations could contribute to enhancing and safeguarding the societal relevance of public health research works and paying more attention to the role of social movements. Members of the research community have called for more involvement by civil society organizations in biomedical (Bhan *et al.* 2007) or public health research (Delisle *et al.* 2005). We acknowledge that these are important steps in the right direction, even if there still is a long way to go. Now is probably the time to make a call for a move in the other direction. Researchers should not be afraid "to get their feet dirty" and involve themselves with civil society activism. It will contribute to shape the relevance of their research and will lead to opportunities to get research findings effectively translated into policies and practice.

To give due attention to the role of social movements in influencing health policy, it will be necessary to ensure the participation of civil society organizations in the research agenda setting, and – in many situations – in the research itself. Illustrative in that respect is the research policy of the Medicus Mundi International (MMI) network organization (<http://www.medicusmundi.org>) that formulates two main challenges for NGOs related to research: "Get evidence into NGO policy and practice!" and "Get NGO practice into research!" (<http://www.medicusmundi.org/en/mmi-network/documents/mmi-research-policy.pdf>) The organization is reaching out to the academe, but insists on a prominent role of civil society organizations in defining the agenda of the research. A first workshop on "Health Systems Research and NGOs – building up mutually beneficial partnerships" organized by MMI took place at the Institute of Tropical Medicine in Antwerp, in November 2010. Based on this experience an advisory group is currently drafting a work plan.

Intal/Third World Relief Fund (<http://www.intal.be>), a Belgian NGO some of us are involved with, is working with local partner organizations to empower communities and particularly the disadvantaged social classes. Although empowerment is largely an endogenous process

and people mostly empower themselves, the support of professionals can be a catalyst in the process. Likewise, research can play a similarly supportive role. Recently, the NGO has been experimenting with the Most Significant Change methodology, a qualitative monitoring method based on storytelling, to enhance its research and documentation (Third World Relief Fund 2010). These and other efforts of NGOs could offer a wealth of data to researchers.

An adequate interface for a productive encounter and a genuine dialogue between civil society and academia thus needs to be established. The precise nature that such an interface must take is a study subject in itself. Context factors will obviously play an important role. For example, the relative disinterest of academia in the North for implementation research – i.e. the 'how' of translating current knowledge into policy and practice within health systems – is definitely a hurdle to take (Chopra & Sanders 2000).

David Sanders *et al.* (2004) have expressed the challenge addressed in this paper as follows: 'Most health researchers to date have only studied the world; the point, however, is to change it for the better'. Therefore, it is time for the research community to engage more than it is the case today with the bottom up processes that are so important in shaping public health policies.

References

- Baldwin P (1990) *The Politics of Social Solidarity: Class Bases of the European Welfare State*. Cambridge University Press, New York.
- Bhan A, Singh JA, Upshur REG, Singer PA & Daar AS (2007) Grand challenges in global health: engaging civil society organizations in biomedical research in developing countries. *PLoS Medicine* 4, e272. Available from: <http://www.plosmedicine.org/article/info:doi/10.1371/journal.pmed.0040272>.
- Blas E, Gilson L, Kelly MP *et al.* (2008) Addressing social determinants of health inequities: what can the state and civil society do? *Lancet* 372, 1684–1689.
- Borrel M (2004) *Industrial Conflict, Mass Demonstrations, and Economic and Political Change in Postwar France: An Econometric Model*. Global, Area, and International Archive, UC Berkeley. <http://www.escholarship.org/uc/item/5nq0p78c>.
- Chopra M & Sanders D (2000) Asking "how?" rather than "what, why, where, and who?". *BMJ* 321, 832.
- Commission on Social Determinants of Health (2008) *CSDH Final Report: Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health* World Health Organization, Geneva.
- Council for Health and Development (1998) *Community Based Health Programs (1973–1998): 25 Years of Commitment and Service to the People*. Council for Health and Development, Manila.

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- De Vos P (2005) “No One Left Abandoned”: Cuba’s National Health System Since the 1959 Revolution. *International Journal of Health Services* 35, 189–207.
- De Vos P, Dewitte H & Van der Stuyft P (2004) Unhealthy European Health Policy. *International Journal of Health Services* 34, 255–269.
- De Vos P, De Ceukelaire W, Malaise G, Pérez D, Lefèvre P & Van der Stuyft P (2009) Health through people’s empowerment: a rights based approach to participation. *Health and Human Rights: An International Journal* 11, 23–35. Available from: <http://www.hhrjournal.org/index.php/hhr/article/view/126/201>
- Delisle H, Roberts J, Munro M, Jones L & Gyorkos T (2005) The role of NGOs in global health research for development. *Health Research Policy and Systems* 3, 3. Available from: <http://www.healthpolicysystems.com/content/3/1/3>
- Elias PE & Cohn A (2003) Health reform in Brazil: lessons to consider. *American Journal of Public Health* 93, 44–48.
- Garfield R & Williams G (1992) *Health Care in Nicaragua. Primary Care Under Changing Regimes*. Oxford University Press, New York.
- Luttrell C & Quiroz S (2007) Linkages between human rights-based approaches and empowerment, Intercooperation and the Overseas Development Institute. <http://www.povertywellbeing.net/en/Home/Empowerment/document.php?itemID=1545&langID=1>.
- Marmot M, Friel S, Bell R, Houweling TAJ, Taylor S & on behalf of the Commission on Social Determinants of Health (2008) Closing the gap in a generation: health equity through action on the social determinants of health. *Lancet* 372, 1661–1669.
- Navarro V (1989) Why some countries have national health insurance, others have national health services, and the U.S. has neither. *Social Science and Medicine* 28, 887–898.
- Sanders D, Labonte R, Baum F & Chopra M (2004) Making research matter: a civil society perspective on health research. *Bulletin of the World Health Organization* 82, 757–763.
- Spieschaert F (2005) *Methodology of Experience Experts in Poverty and Social Exclusion. Foundations, Training and Operation*. Acco, Leuven, Belgium, 146 p.
- Szreter S (1997) Economic growth, disruption, deprivation, disease and death: on the importance of the politics of public health for development. *Population and Development Review* 23, 693–728.
- Szreter S (2003) The population health approach in historical perspective. *American Journal of Public Health* 93, 421–431.
- Third World Relief Fund (2010) *Most Significant Change: Monitoring Empowerment for the Right to Health*. Available from: <http://www.slideshare.net/intalinfo/brochure-msc-engweb>.
- Turiano L & Smith L (2008) The catalytic synergy of health and human rights: the people’s health movement and the right to health and health care campaign. *Health and Human Rights: An International Journal* 10, 137–147. Available from: <http://www.hhrjournal.org/index.php/hhr/article/view/31/117>
- Unger JP, De Paepe P, Buitrón R & Soors W (2008) Costa Rica: achievements of a heterodox health policy. *American Journal of Public Health* 98, 636–643.
- WHO (2008) *The World Health Report 2008 – Primary Health Care: Now More than Ever*. World Health Organization, Geneva, p. 35.

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