THE SOCIOLOGY OF HEALTH IN NEW ZEALAND

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[This is the course material for a module on the sociology of health within the paper 176.102 New Zealand Society, taught by Associate Professor Peter Beatson in the Sociology Programme, Massey University, between 1988 and 2007. The present module was written in 2005 during the regime of a coalition Labour government, and it will obviously not incorporate changes that have subsequently occurred. Nevertheless, although some of the facts contained in this text may now be a little dated, and a different political party will be in power, the analytical framework set out in the following text, and its advice about how to conduct a sociological study of health, are as relevant now as when the module was first written.]

SECTION ONE: SOCIOLOGY AND HEALTH

The Relevance of Sociology to Medicine

For the uninitiated, sociology and medicine may not seem to have much obvious relationship with each other. When you are ill, you just want to be cared for and to get better. The people you turn to are medical practitioners of one sort or another – doctors, nurses, physiotherapists, chiropractors, tohunga or whomever. They are the ones who are dedicated to our physical and mental well-being, and who can provide the specialist services and medicines we require. Where does sociology come in? After all, sociologists cannot perform surgery, manipulate bad backs, write out prescriptions, assist childbirth, diagnose schizophrenia or whatever, and they are not likely to want to bathe us or empty our bedpans. Why bother with sociology when there are more pressing, practical matters to concern us? This is the challenge we are taking up in the following pages, which are all directed in one way or another towards the question just raised: ‘What relevance has sociology to medical matters of illness and injury?’.

The answer we propose is that although sociologists may not be of much direct use treating sports injuries, coping with a flu epidemic and the like, there is a great deal of useful light they can cast on a host of social factors that directly or indirectly have a significant impact on such medical matters. Caring and curing do not take place in a social vacuum. They are embedded in social and cultural contexts which have a crucial influence on the causes of good or poor health, the rate of injuries, and the ways in which patients are treated.

Furthermore, the incidence and treatment of illness and injury can in turn affect the wider social environment. Sociology helps us understand the two-way processes whereby society affects health, and medical practices affect society. Such understanding may not qualify us to cure illness, but it does help us to analyse the
complex and tangled issues involved in the health game. This analysis may enable us to suggest ways that the game can be played more effectively and humanely.

**Conducting Sociological Analysis**

If the job of sociologists is to analyse medical issues in their social context, how is this analysis to be conducted? More precisely, what exactly do we mean by the words ‘social’ and ‘society’? The problem is that everything in human affairs has a large social component. Education, work and politics are social phenomena. Gender identity, ethnic relations and class status are societal in their origins and consequences. Society creates systems of justice, health and welfare. It defines beauty and ugliness, normality and deviance, truth and falsity. Society is as ubiquitous as the air we breathe.

Thus, to say that health must be analysed within its social context is only a broad, general orientation. It is the starting point for further and more specific sociological investigation, not an end in itself. Such investigation requires us to be much more specific about what we mean by society, and precise about the elements of which it is composed.

**The Need for a Social Map**

What is needed is a ‘map’ of society which will allow us to grasp social life in its totality, and also enable us to break it down into its major component elements. It should show how the parts fit together to create the whole, and also reveal major fault lines where society is divided against itself, where pressures mount up and social earthquakes are likely to occur. Such a conceptual map would provide an analytical framework, through which that amorphous blob ‘society’ could be given rigorous, intellectual definition, its workings described and its relevance for health more accurately perceived.

It is precisely such a task of intellectual cartography that is being undertaken in this module. The social map on which it is based can be imagined as seven concentric circles surrounding a doctor and a patient, with ‘Nature’ as the outermost and most objective sphere, and ‘Culture’ as the innermost and most subjective. For convenience, the following shorthand labels can be attached to these concentric circles, starting at the natural periphery and working inwards to the cultural centre:

- Nature
- Economy
- Population
- State
- Welfare
- Community
• Culture

Taken together, these seven spheres comprise the social context with which sociologists of health are concerned. Here are a few, brief, explanatory notes on each, which will be expanded and explored more fully as the module unfolds.

Nature
Nature is the objective infrastructure of all human life. It can be thought of as coming in two parts. On the one hand, there is the external environment by which we are surrounded. On the other there are the bodies in which we are clothed. Our bodies, of course, are parts of the objective physical world, but we have a special relationship to them, so it makes sense to put them in a class of their own. When we talk about nature in the rest of this study guide, we shall be referring first and foremost to our own physical organisms, not their natural environment – although the latter will still have a significant role to play.

Economy
This is the sphere in which we meet our material needs, provide services for others, and when possible satisfy our desire for comforts, luxuries and entertainment. The way the economy is organised in any given historical epoch is termed ‘the mode of production’. Even the most elementary mode of production requires six ‘factors of production’: raw material, labour, technology, leadership, knowledge and consumers. Advanced economies add two others to the mix – money and the state. Today, all eight are essential for the processes of production, exchange and consumption, but arguably the most important is money, since without this precious economic fuel all other activities tend to grind to a halt.

Population
As with all living species, the basic building blocks of human societies are the biological bodies of which they are composed. Since biology condemns us all to die, if a society wishes to stay in existence, its present members must reproduce themselves, or else new members must be recruited from outside. Birth, death and migration are the three key demographic processes. Depending on how they interact, they determine the size, the composition and the distribution of a country’s population.

The state
Once societies develop beyond the tribal stage, they have a functional need for an overall governance body that will hold their disparate parts together, impose law and order, provide for citizens’ needs, and defend the country’s territorial frontiers against invasion. To perform these functions, the state has three imperative requirements: the ability to impose its will by force, a regular money supply, and an aura of legitimacy. If it possesses these, a government can set the ground rules by which the social game is played. One of the most important of such rules is the degree to which the state has the right – and perhaps the responsibility – to interfere in the lives of its citizens.

Welfare
This is the sphere of the social map with which we are concerned in the present study guide. It is the sharing, caring zone of society, in which it looks after the well-being of its members by making provision for the needs of those who, through poverty, poor health, disability or various forms of vulnerability, are not fully able to provide for themselves.

**Community**
A community is an informal, emotionally charged group or network whose members feel they belong together, either through personal interactions or through sharing the same experiences, symbols and values. It may be called the ‘relational’ sphere, since in it people subjectively relate to others as meaningful human beings, rather than treating them as instruments for the achievement of objective ends. Literally or metaphorically, community members are family, holding a common worldview which may harden into a kind of ‘group mind’. This may make them suspicious, resentful or even hostile towards members of other communities, with whom they compete for what might variously be termed status, honour, esteem, standing, respect or mana. Status striving is one of the most powerful human drives, and community is the site in which it occurs.

**Culture**
Culture is a people’s entire way of life – its shared world view or group mind. It comprises stores of knowledge, moral codes, life styles and sacred beliefs, symbols and rituals. All of these are constructed and communicated through various sign systems of which the most important is language. Just about everything people take for ‘reality’ is actually created through culture. This sets the human species apart from all other life forms. Other organisms live mainly in nature; humans live mainly in culture.

Here, then, are the seven spheres of the social map, expressed in very general terms. In the rest of the module, these generalisations will be unpacked by relating them to the specific topic of health.

**Causes and Consequences**

Having introduced the seven strands from which the social tapestry is woven, we will now add a few other tips for beginners about ‘doing sociology’.

First of all, one of the main tasks of sociologists is to uncover and describe both the causes and the consequences of the phenomenon they are studying. If a whole lot of children from the same school come down with a mysterious stomach complaint, what caused it – food poisoning? A bug? Polluted water? Group hysteria?...

That settled, the next question concerns the results of the outbreak – someone getting sacked? a commission of enquiry into environmental hazards? an outcry about inadequate facilities at the local hospital?... We have to trace complex waves of cause and effect right across the social pond, from the moment the first pebble was dropped into it, to the last little subsequent ripple.
Our second piece of advice to budding sociologists is never to be content with identifying just one cause and just one consequence. We must be ‘multi-factor theorists’. When something happens in society, it seldom if ever is the result of just one causal factor, and its impact equally is seldom limited to just one consequence. If we start probing, we are likely to find that factors from several – perhaps all – spheres of the social map conspired to bring the event about, and that its consequences, too, are likely to spread out into many sectors, like the ripples just mentioned.

Applying this to our present subject – health – we can represent the level of physical and mental well-being of an individual, a social category or even the entire country as the outcome of a complicated equation involving all parts of society. It would look like this:

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\text{NEPSCoCu(LM)} = H
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Obviously, H in this equation stands for ‘health’, N for ‘nature’, Co for ‘community and so on. However, you will not know why the mysterious letters L and M appeared in the equation. They stand for ‘luck’ and ‘muddle’. These are not actually things which sociologists talk about much, as they are hard to study scientifically, but we all know from first-hand experience of illness and injury, and from our subsequent encounters with the medical system, that health outcomes can be strongly influenced by sheer chance on the one hand, and on the other by the confusion and mayhem endemic in some health services.

**Luck and Muddle**

Taking the luck factor, we may live pure and blameless lives, never touching a cigarette, taking plenty of exercise, eating loads of fresh fruit and green vegetables, yet still come down at an early age with cancer, for the quite unfair reason that a rogue gene responsible for the disease runs in the family. Conversely, we may avoid being injured in a road accident by a chance encounter with a friend that kept us talking for a few minutes before getting into our car, thus avoiding the smash taking place up ahead as we dally and chat. Sociologists, who tend to deal in regularities, have little to say about such arbitrary quirks of fate. Nevertheless, our physical and mental well-being depends in large measure on nothing more than good or bad luck.

Then there is the great god Muddle whose evil genius seems to preside over many aspects of the health system – notably in hospitals. We are talking here about the legendary ‘**Murphy’s Law**: If anything can go wrong, it will. In principle, medicine is a rational and technically efficient system of applying scientific procedures for the achievement of planned outcomes. The principle of technical rationality applies both to medical practices themselves and to the administrative systems within which they are embedded. A hospital, for instance, is a highly organised bureaucratic machine, operating through horizontal task specialisation and hierarchical chains of responsibility, the whole organisation geared for the most effective mass processing of the thousands of patients requiring its services each year.

In practice, however, the surface veneer of managerial lucidity and technical rationality is frequently cracked by Murphy’s law. Quite simply, things go wrong. Equipment breaks down, mistaken diagnoses are made, patient notes get lost,
surgeons operate on the wrong part of the body, drugs have unforeseen side effects, personnel do not communicate adequately with one another, patient numbers swamp an under-staffed team of over-worked doctors and nurses, funding unexpectedly dries up, blood gets contaminated, test results are misinterpreted... The list could go on.

At the least, malfunctions in the medical system are stressful for all involved; at worst they can have tragic outcomes. People can end up after medical treatment worse off than when they started. Since 2004, it has been possible to gain compensation from ACC (the Accident Compensation Corporation) for medical misadventure – that is, mistakes made by medical staff. This may be a minor consolation, however, if you emerge from hospital minus a leg that was mistakenly amputated. There is no ACC recompense for the many forms of irritation and frustration inflicted unnecessarily on large numbers of patients by the muddle endemic in the health services.

What we are talking about is the human fallibility that bedevils even the most scientifically and administratively rational of organisations. We shall not return to this subject in the following discussions of the various spheres of the social map, but it is essential to give it a mention here, as Murphy’s law operates in and between all those spheres. Indeed, the main impression we may take away from our encounters with the health system may not be of its miraculous healing powers, but its frustrating delays, mistakes and muddles.

Issues

The final piece of sociological advice we have to offer is that you should home in on key issues in the fields you are exploring. Putting it simply, by an ‘issue’ is meant something people argue about. Sometimes it is an intractable problem to which there is no obvious, easy answer. One such problem bedevilling the health system is how to allocate finite financial resources. Since the government only has a certain amount of money to spend on health, amongst all its other funding commitments, who should get it?

Another breeding ground of divisive issues is the fact that people have different and sometimes incompatible interests, values and priorities. Some Māori people, for instance, want more deference paid to forms of traditional, supernatural healing, but this flies in the face of modern, scientific views about natural cause and effect.

The health sector is an arena where many gladiators contend, all insisting that their particular views should triumph over others. Our job as sociologists is to identify the following factors in any given issue:

- Who are the main actors?
- What are they arguing about?
- What is motivating them?
- What kinds of resources can they mobilise to promote their cause?
What would be the consequences if one particular position prevailed?

**Power**
The most important ingredient in all issues can be summed up in the one word ‘power’. One thing which all individuals, communities, organisations, states and international blocks have in common is a will to power. When conducting sociological analyses, therefore, we must always be alert to the power games that are covertly or overtly being played.

‘Power’ is a very broad term, however. It is useful to distinguish between the different forms it can take. It can be thought of as coming in three general guises:

- Power to...
- Power over...
- Power from...

The first of these can also be called ‘empowerment’. Power in this aspect is simply a form of energy – the social equivalent of electricity or petrol – that is required to get things done. To achieve our goals in life, no matter what these are, we need psychic energy, and we need material and cultural resources. Much that goes on in the medical world involves ‘power to…’ People become ill or injured; medical practitioners want the power to heal them.

The second form of power can also be called ‘domination’. In this form, power is the ability of individuals or groups to impose their will upon others, even against the latters’ wishes. Forcibly locking people up in psychiatric hospitals and administering punitive treatment is a case in point. So, too, is a doctor abusing his professional position to coerce sexual favours from a client.

Finally, there is ‘power from…’, which might also be called ‘defensive power’. This is where we mobilise our resources to fight off the despotic power involved in domination. Examples are the Aotearoa Network of Psychiatric Survivors, which was formed to fight against abuses of power by mental health professionals, and the New Zealand women’s health movement, which challenged patriarchal dominance in the medical profession.

Power will be a ubiquitous theme in the following pages, as it is in all human affairs, so keep an eye out for it, and the diverse forms it assumes. Watch out also for the various other pieces of sociological advice outlined above. They will all be woven into the fabric of the text as we put health on the social map.
SECTION TWO: NATURE

Humanity’s Roots in Nature

Like everything else on this planet, the human species is part of the natural world. Along with all other life forms, we are biological organisms, and are subjected to the same natural laws of cause and effect as the rest. Nature is the objective infrastructure of all human existence.

Each sphere of the social map has its ultimate ground in Papatuanuku – Mother Earth. Economic activity begins with the extraction of raw materials from nature. Populations are ruled by the two biological processes of birth and death. The major defining characteristic of the state is that it controls a specific geographical territory. Communities often derive their sense of identity and continuity from their relationship with a patch of earth they feel to be their home base. Even culture, which is at the furthest human remove from nature, could not exist without a physical infrastructure drawn ultimately from the natural world. After all, the central repository of culture is the human brain, and brain anatomy and physiology are objective, natural phenomena.

Thus, in every sphere of the social map human beings live in nature as well as in society and culture. Sometimes they draw sustenance from nature, sometimes they struggle to dominate it, sometimes they are overwhelmed by it – but it is always there. It is experienced as the external environment of our lives with which we must constantly interact. It is felt even more intensely and intimately in the form of the bodies with which we must journey through life, and which provide the basic raw material of our identity, such as sex, appearance, ability and age.

Ignoring Nature

All this may seem too obvious to need saying. Nevertheless the vital bond between human society and its natural context does require emphasising, as in our daily round we frequently forget, and sometimes even deny, our roots in the earth. Since the advent of industrialisation, many people in the developed world have lost their direct, first-hand relationship with nature. They do not have to provide for their own basic needs like food and water, they are protected from the weather by snug clothes, air-conditioned workplaces, and travelling cocoons called motorcars, and they have slaves like electricity to replace their own physical energy. The natural environment once dominated the foreground of human life. It has now retreated to the periphery as something to be contemplated and enjoyed, rather than a force to be reckoned with at every turn.

There is more to the human tendency to downplay the significance of nature than our newly found ability to ignore it thanks to industrial progress. Influential world religions like Judaism, Christianity and Islam, along with many forms of secular
philosophy, have convinced vast numbers of people down the millennia that there is a wide and unbridgeable gulf between humans and the rest of nature. They have been indoctrinated with the notion that humans are qualitatively different from all other natural phenomena, and infinitely superior to them. The religious explanation for the alleged difference is that humans have souls, and that these souls have a special, privileged relationship with a cosmic supernatural being. At the limit, certain religions preach that everything about nature is actively evil, or alternatively is just an illusion. Secular philosophy, on the other hand, locates human superiority in higher mental faculties such as Reason, Conscience, Imagination or Creativity that we alone possess.

Whatever the metaphysical justification, many people down the ages have been conditioned to accept without question the belief that humans stand apart from and above the rest of nature. The latter must be dominated and exploited. With such a mind set, people are not likely to take kindly to the notion that in the first and last instance they are simply biological organisms, subjected to the same laws of cause and effect as all other natural phenomena.

There are thus two main reasons why we often ignore the ubiquitous presence of nature. On the one hand, technological progress makes it unnecessary for many people in the developed world to engage in constant, hand-to-hand combat with nature. Industrialisation has pushed it from the centre to the margin of our lives. On the other hand, culture has programmed us to believe we inhabit a different and superior sphere of existence to all other earthly phenomena. Religion and philosophy have enjoined us to rise above nature – to be god-like, not bestial.

**Illness and Injury: Nature’s Revenge**

Unfortunately, no matter how much we ignore nature, it persists in recognising us. As we go about our affairs with our proudly human heads held high, we are constantly being brought back to earth with a bump as we stumble over trip wires nature has planted in our way. Like it or not, we are parts of the natural world, and much of who we are and what we do is determined by that fact. This is brought home to us most forcefully of all in the sphere of the social map we are about to explore. The whole health system is based on the fact that nature persists in making disruptive assaults on the physical organisms in which we are housed.

Those organisms are miracles of bionic engineering. They have evolved by trial and error over millions of years into amazingly complex, superbly functional mechanisms for sustaining and perpetuating human life. Each finely adapted sub-system of the body goes about its business in unison with its fellows, manipulating our limbs, passing sensory stimuli to the brain, pumping blood, inhaling and exhaling air, secreting chemicals, transmitting electrical impulses, adjusting temperature, digesting nutriment and so on. Most miraculously of all, the entire workings of this finely crafted organism are orchestrated by that supremely complex and efficient biological system – the brain.

Much of the time, this natural infrastructure – above all the brain, – operates without our conscious awareness. So long as our organisms are in good running order, they are largely invisible to us. We just get on with our human ends and leave it to biology
to provide the means. Like the engine under the bonnet of our car or the electricity on which our domestic appliances rely, we typically do not spare a thought for the anatomy and physiology of our own bodies.

This cavalier disregard for the finely tuned workings of our own organisms abruptly vanishes, however, when they are damaged, malfunction or pack up altogether. At that point, nature gets its revenge for being ignored. When things go wrong with our biology, we are insistently reminded of how vitally dependent we are upon it for our ability to function in all other spheres of the map. Not only do we find it difficult or impossible to work, to perform our family and community roles and the like, but life in general loses much of its savour. We tend to become obsessively focused on the part of our body which is playing up – a wisdom tooth, our lungs, a hip joint or whatever – to which normally we would not give a second thought. Even more oppressively, when bugs run rampant throughout our system we experience a general malaise that affects our whole sense of well-being.

It is most devastating of all when it is our brain that is malfunctioning, as this undermines our basic sense of identity, as well as often engendering a range of debilitating physical symptoms classed under the general diagnostic term ‘depression’. Why mental disorder is so particularly distressing is that people are often unaware that what they are experiencing is indeed an illness. They may instead feel there is something wrong about that intangible human essence called ‘the self’. If chronically depressed, I may feel it is not my brain that is the problem, it is me. This makes the condition even more difficult to bear, as I may feel shame or guilt about being a failed human being.

Culture to the Rescue

Whatever the source and symptoms of the pathology, it tends to dominate our lives to the exclusion of everything else. Amongst other things, sick people often become self-absorbed. Their over-riding drive is to shake off the condition that is undermining the quality of their lives and their ability to function as full members of society. In short, they are desperate to be cured, and sometimes they can think of little else. They just want the black dog off their shoulder.

First and foremost, this will require a diagnosis. A specialist must figure out precisely what has gone wrong. In some cases, just being given such a diagnosis may in itself be a relief, particularly with mental disorders or bodily ones with diffuse, generalised physical symptoms. Giving the condition a respectable medical name proves to us and to others that we are not just malingering, hypochondriacal, or being plain bloody-minded. Once certified by a medical practitioner as officially ill, we can sink into what sociologists call ‘the sick role’ with a clear conscience, perhaps even enjoying being nursed and fussed over, and let off our normal responsibilities.

Above all, though, we want that black dog off our shoulder, even though this probably involves taking pills, undergoing surgery, and/or undertaking some disagreeable form of therapeutic regimen. Whatever the treatment, we put ourselves in the hands of specialists, who are – or who claim to be – wise in the ways of physical and mental pathologies. Now the contest begins!
What ensues once we consult a medical practitioner is an epic struggle between nature and culture. On the one hand there is our wayward biological organism, on the other the cultural expertise through which our pathology is interpreted and cured. Unlike all other life forms, which must cope with illness and injury as best they can from their own natural resources, humanity has a unique ally in the vast storehouses of knowledge that have accumulated in the cultural domain down the epochs. It is culture which supplies the theoretical explanations of how illness is caused, and it is again culture that furnishes the technical know-how to heal it.

 Cultures differ, however, in their approaches to health issues. One of our major tasks as sociologists of health is to explore the diverse ways that cultures in different ages and societies have gone about constructing their causal theories of illness, their diagnostic techniques and their therapeutic practices. All three of these are cultural, but they vary immensely from epoch to epoch, and from one society to another. Sociology’s role, amongst other things, is to highlight the differences and explain their significance. This is the task that will be undertaken in Section Seven of this study guide.

**Arguments Against Biological Causality**

Now for a cautionary note. There are two factors that need mentioning which complicate our above assertion that good or bad health is the outcome of a contest between nature (i.e. human biology) on the one hand, and culture on the other. There are those who hold that biology plays no part in the origins of illness, and is therefore irrelevant to its cure. An opposite argument can also be mounted – that is, the human body and mind have remarkable powers of self-healing, and culture is therefore pretty much irrelevant to our recovery from illness.

Taking the first of these, there are many theories of illness that flatly deny the seemingly uncontentious premise that illness has natural origins. Throughout most human history, and even today in many quarters, it has been assumed that disorders have supernatural rather than natural origins. They are caused by black magic, the violation of tapu, the anger of a god, demonic possession and so on. Their treatment, too, must therefore be supernatural. Illness, in short, is a spiritual matter, not a natural one. Therefore, it must logically be cured by spiritual means. Being given a shot of penicillin is not much use if your disease was caused by someone casting a spell against you. An operation will not help your blindness if it was caused by lack of religious faith. If an evil spirit has taken over your mind, anti-psychotics will be of no avail. In short, you do not need a doctor, you need a religious expert of one sort or another, be this a tohunga, priest or faith healer.

It is not just faith healers and the like who deny the biological basis of illness, however. The same scepticism can be found amongst secular theorists, although for very different reasons. It can be seen most clearly in what has been termed the ‘anti-psychiatry’ movement, which started in the late 1950s and has been gathering credence ever since.

The medical science of psychiatry tends to treat mental disorder as a malfunction of brain physiology, often vaguely termed ‘a chemical imbalance’, to be treated with
doses of pharmaceuticals and perhaps a course of electro-convulsive therapy (commonly known as ‘shock treatment’). The anti-psychiatry movement hotly disputes this so-called ‘bio-medical’ approach to mental disorder. At its most radical, it even claims that the whole notion of ‘mental illness’ is a myth cooked up by psychiatrists to increase their own authority, status and earning power.

Less extreme opponents of the bio-medical approach to mental disorders are prepared to concede that they are indeed illnesses, but dispute their origins in brain chemistry, neural transmitters and the like. They maintain instead that mental conditions have their origins in traumatic experiences or destructive relationships. Sometimes these are said to date back to events in early childhood, such as sexual abuse, which may lie buried in the minefield of the subconscious mind until triggered off by something in the present. Those who do not accept the contentious theory of repressed childhood memory nevertheless hold that mental illness is caused by current stress. Either way, it is the external relationship between the self and its human environment which causes the disorder, not chemical or electrical pathologies in the brain. Consequently, it is at best irrelevant, at worst extremely harmful, to bombard patients’ brains with mood-altering medication or electric shocks. If biology is not the culprit, it is pointless prescribing biological remedies.

We shall come back to these issues when we explore the cultural sphere, but they need to be pointed out here, as they reveal that our starting assumption – illness involves a struggle between nature and culture – is strongly contested in many quarters. People ranging from tohunga to consumers of psychiatric services may concede that illness manifests itself through physical symptoms, but claim that its cause and its cure belong in the domains of either the supernatural or the mind. Nature doesn’t come into it.

**The Self-correcting Organism and the Placebo Effect**

Now for a second cautionary note about our assertion that medicine is primarily a stand-off between nature and culture. What we will say here is the opposite of the point we just made – that is, the belief that illness is not primarily a biological phenomenon. At the other extreme from this is the undeniable fact that our natural organisms, off their own bat, do a great deal of repair work and healing without any recourse to medical intervention. Earlier, we mentioned the brilliant bionic engineering of the human body. This includes the in-built capacity of our immune systems to fight off invading germs, and our body’s ability to repair damaged parts of itself, and even to manufacture do-it-yourself anaesthetics called endorphins. Doctors increasingly acknowledge that many forms of illness and injury may come right of their own accord, without heroic medical intervention.

This, for instance, was the assumption underlying an experiment at the National Women’s Hospital conducted by Herbert Green that will be discussed later. He believed that early symptoms of cervical cancer should be left untreated, rather than being cut out by surgery. When this experiment came to light in the late 1980s it set off a major controversy, but although it was unethical to use women as guineapigs, Green’s theory that it might be best to leave the body to fix itself was not altogether cranky. Many doctors – and their patients, for that matter – might well agree that a
A conservative, wait-and-see approach is preferable to possibly dangerous surgical intervention.

If self-curing does indeed occur, it may be achieved through the positive attitudes of patients themselves, helped by supportive relationships. We are not endorsing extreme ‘mind over matter’ theories of healing, but there is plenty of evidence to suggest that an optimistic mindset may contribute to the healing process.

A positive attitude, however, may need to be triggered off by what is termed ‘the placebo effect’. Placebos are substances, like sugar pills, which have no actual therapeutic power, but which are administered during tests of real drugs to see if the latter are effective. Some people in the test get the drugs, the others take placebos. It is often found that some of those who take the sugar pills recover from their symptoms. The conclusion is that people may be healed, partially and temporarily at least, through the very act of taking alleged medicine, no matter what it contains. They have faith in medical experts, that faith translates into a positive attitude towards their illness, and this in turn brings about an apparent cure.

It is not always a matter of taking pills, though. The placebo effect may be found in other forms of healing as well. Faith healers and practitioners of what are called ‘alternative’ or ‘complementary’ therapies often claim to produce results as good as – or even better than – scientific medicine. The active ingredient in the healing process, however, may not be the supernatural powers of spiritual healers, nor the secular efficacy of herbs, aromas, colours, crystals, needles or whatever, but the patient’s belief in the healer and/or the therapy. People sometimes get better – or believe they do – as a result of alternative therapies, even though there is usually no scientific explanation for their recovery. The body has fixed itself, thanks to the positive attitude of the patient. As with laboratory placebos, perceived cure is effected by faith in the healing process, not by the process itself.

There is no hard way to quantify the placebo effect, but it does seem the case that some people, on some occasions, think their way to better health, even where there is no objective reason for their recovery. Culture, in diverse guises, takes the credit for cases of healing that may have purely natural causes. Why we bring up this issue is that sociologists try to say something meaningful about the role of culture in the healing process. This gets complicated when patients’ bodies have actually cured themselves, regardless of whichever expert takes the credit. It makes things hard for sociologists to figure out the precise role of culture in the healing process, and to judge the merits of different medical systems, when the real therapist was nature itself.

We have now issued two cautionary notes about the sociology of health as it will be discussed in the following pages. One was that many people deny the natural origins of disease. The other and opposite point was that in some cases nature (with a bit of help from a positive attitude) does all the healing by itself, even though supernatural, alternative or scientific experts claim the credit. With those provisos in the back of our mind, we shall now sally forth from the domain of nature to discover how the remaining spheres of the social map influence our health, and are in turn influenced by it. Right at the end of this long voyage of discovery, we shall return full circle to the issues we have just raised about the epic struggle between nature and culture.
SECTION THREE: ECONOMY

In this section, we shall explore two major aspects of the economic sphere of the social map in which sociologists of health take particular interest. One concerns the general relationship between health and the economic structure of the country as a whole. The other analyses the medical system as a mini-economy in its own right. Throughout, we shall be homing in on the key issues generated by these two topics—that is, the intractable problems they generate and the controversies which surround them. The discussion is intended to furnish a number of significant facts and ideas about the link between economy and health, while at the same time illustrating the more general usefulness of the ‘social map’ presented at the start.

The Socio-economic Determinants of Health

The first sociological point to be made concerns the part played by socio-economic status (SES)—which can also be called ‘social class’—in matters of health. Strictly speaking, SES and class refer to slightly different things, but to avoid muddying the water with conceptual distinctions, we shall treat them here as more-or-less synonymous.

Measuring Socio-economic Status

In principle, all New Zealand citizens are equal, having the same political, legal and human rights. In practice, a hierarchy of wealth, power and status exists. There are various ways in which sociologists identify the different rungs on the SES ladder, and measure the distance between them, but the single most important factors are wealth and income. Just about every other indicator of SES is associated with this core financial one. Roughly speaking, the more money you have at your disposal, the higher your social class.

To arrive at a fuller picture of the class system, however, other ingredients are usually added to the mix along with income. Important among these is employment. Families can be placed on the class map according to whether adult members are gainfully employed and, if so, what kind of work they do. This obviously affects the household income, but it also involves an intangible but socially significant quality variously termed status, standing, esteem, distinction, respect, honour or mana. Some occupations have more status than others. There is more distinction in being a doctor, for instance, than a factory hand. There is also a status ladder within each occupation itself. Junior medical registrars, for example, have less standing in the hospital hierarchy than lordly senior consultants.

Another key determinant of SES, along with income and occupation, is education. People are equipped with differing amounts of what is sometimes called educational capital, which can be measured, amongst other things, by the numbers of years they stayed in the education system, and the formal qualifications they accumulated. Employment opportunities tend to increase in proportion to educational capital and so, too, does esteem.
To arrive at a more fine-grained description of where people are located on the class map, various other ingredients can be stirred into the mix. For instance, the measure of socio-economic status that is most commonly used by health statisticians in this country is the New Zealand Index of Deprivation (NZDep2001), which compares different neighbourhoods (called meshblocks) according to factors such as income, transport (access to a car), living space, home ownership, employment status, qualifications, and support (e.g. sole-parent families). You can see this index put into action in the book Portrait of Health in the Further Readings. However, we do not want to get sidetracked onto an exposition of the various ways SES can be measured. The main point to emphasise is that New Zealand is a class-based society, and that this is highly relevant for a sociological study of health.

**Correlation between Class and Health**

There is a direct correlation between people’s socio-economic status and their health status. Quite simply, the poorer people are, the greater their likelihood of experiencing illness and injury. (By ‘poverty’ is generally meant having less than 60% of the median New Zealand household income to live on.) This correlation is not an absolutely iron law, of course. People right across the class spectrum fall sick or have accidents. Being wealthy does not guarantee good health, and being financially disadvantaged does not automatically mean you will be unhealthy. We are only talking statistical probabilities. That said, all research and surveys regularly arrive at the same conclusion. Good and poor health are distributed unequally, and this health inequality correlates closely with the class gradient. The economically well off tend to be rich in health as well as material goods; as economic prosperity declines, so too do physical and mental well-being.

Evidence of this correlation can be found in a 1998 publication by the national health Committee called *The Social, Cultural and Economic Determinants of Health in New Zealand*. The same conclusions are reached in more recent surveys released by the Ministries of Social Development and Health, respectively entitled *Social Report 2004* and *The Health of New Zealand Total Population 2004*. Indeed, all the books relating to health in this module’s list of Further Readings point the same way. The fact that health and SES go hand-in-hand has become a sociological ‘given’. Rather than picking out a variety of illustrative quotes from different sources, we are including below an extended selection of passages from just one place. This is the Summary of the findings contained in *The Social, Economic and Cultural Determinants of Health*, which pulls together a wide range of research. Although it was written around a decade ago, its generalisations still hold good today, including the rather depressing facts about Māori and Pacific Islander health:

The social and economic factors that have been shown in a variety of settings to have the greatest influence on health are income and poverty, employment and occupation, education, housing, and culture and ethnicity. There is now good evidence that social, cultural and economic factors are the most important determinants of good health.

Income is the single most important modifiable determinant of health and is strongly related to health and well-being. The link between poverty and ill health is clear; with few exceptions, the financially worst-off experience the highest rates of illness and premature death. Greater income inequality within society may also be
associated with increased overall mortality.

The main factor determining adequate income is participation in paid employment, particularly full-time employment. Employment also enhances social status and improves self-esteem, provides social contact and a way of participating in community life, and enhances opportunities for regular activity, which all help to enhance individual health and well-being. Unemployment is detrimental to both physical and mental health and unemployed people in New Zealand report poorer health status than people who are employed. Māori, Pacific people and young adults have much higher rates of unemployment than the general population.

Education is critical in determining people’s social and economic position and thus their health. A low level of education is associated with poor health status. Over 60% of Māori, Pacific people and members of other minority ethnic groups are functioning below the level of literacy required to effectively meet the demands of everyday life.

Overcrowding, damp and cold have direct detrimental effects on physical and mental health. High housing costs leave less money for other budget items essential to good health, including nutritious food, education, and access to health services. Over recent years, there has also been an increase in hospital admissions from childhood diseases that are known to be associated with overcrowding, including meningococcal disease and respiratory infections.

Māori experience an excess burden of mortality and morbidity throughout life, starting with a higher infant mortality rate (mainly due to SIDS), higher rates of death and hospitalisation in infancy, childhood and youth (predominantly from injuries, asthma and respiratory infections), and higher mortality and hospitalisation rates in adulthood and older age (especially from injuries, cardiovascular disease, diabetes, respiratory disease and most cancers). The relatively poor health status of Māori results from a number of factors but it is mostly due to poorer socioeconomic circumstances than non-Māori.

The health of Pacific people in New Zealand has improved over recent decades, but they still experience a heavy burden of avoidable morbidity and mortality. Pacific people living in New Zealand have the highest national rates of meningococcal disease, rheumatic fever, rheumatic heart disease and obesity. Other important health problems are an increasing rate of SIDS, low immunisation rates, high rates of hospitalisation in children, particularly for pneumonia, asthma and middle ear infections, and high rates of diabetes, tuberculosis and liver cancer in adults. The low socioeconomic status of Pacific people explains much of their comparatively poor health status.

People in the lowest socioeconomic groups consistently have the poorest health status. There are persistent socioeconomic inequalities in health status in New Zealand as measured by mortality, hospitalisation and self-rated health. Despite an overall improvement in population health status, socioeconomic inequalities in health have not decreased over the past two decades and may even be increasing.

**Reasons for the Link between Class and Health**

There is a constellation of related reasons why socio-economic disadvantage tends to generate poor physical and mental health. Many stem directly from the material deprivation associated with poverty. Deprived families are not always able to afford
healthy food. Their houses may be inadequate and over-crowded, making them breeding rounds for what are termed ‘diseases of poverty’, such as tuberculosis, rheumatic fever, bronchitis, meningococcal B and ‘glue ear’. Manual labour is another causal factor. Working class employees tend to be engaged in the kinds of occupation, such as factory, construction, forestry and farm work, that generate a disproportionately high number of industrial injuries.

More intangible factors are at play as well, though. On the psychological front, life on the poverty line can cause a high level of stress, fatigue and anxiety, particularly for sole parents (of whom the vast majority are women). A contributing factor is unemployment, which is disproportionately high amongst lower SES classes. Being involuntarily out of paid employment often takes a heavy emotional toll, both on the unemployed and their families. Stress tends to manifest itself in emotional or mental disorders, notably depression, or else in self-destructive coping mechanisms like drinking, gambling, smoking or taking drugs. These give temporary release but aggravate problems of material deprivation and poor health.

Cost is another factor. While a comfortable income insulates households from diseases of poverty, the well off have the further advantage that when they do suffer health problems, paying for treatment makes less of a dent in the overall family budget. The deterrent effect of doctors’ bills was graphically revealed by a 2004 survey (http://www.cmwf.org) which showed that while the overwhelming majority of New Zealanders personally liked their doctors, a quarter of those surveyed did not get the health treatment they needed because they could not afford a visit to their GP and/or because of the cost of picking up prescriptions.

Furthermore, if poorer members of the national community require elective surgery (operations for conditions that are not actually life-threatening, like cataracts, varicose veins or arthritic hips) they have to go onto long waiting lists to get a free operation in a state-funded hospital. Those further up the class hierarchy can avoid the queues by paying for surgery in private hospitals out of their own pockets.

Better-off families are also able to afford health insurance with companies like Southern Cross, which helps cover the costs of such private treatment. Insurance, though, is a luxury a decreasing number can afford. For one thing, premiums cost more the older you get – that is, they grow more expensive at the time of life when you most need health care but can least afford to pay for insurance. In all, only about a third of New Zealanders hold medical insurance policies. The rest rely on state-funded hospital services, with the accompanying delays and frustrations. There is thus a two-tier hospital system in this country, one providing fast, personalised care for those who can afford to ‘go private’, the other offering slower, more impersonal services in the public sector.

**Perverse incentives and the inverse care law**

Now another class-related factor will be added to the mix. This is that primary health services (i.e. those provided by medical practitioners out in the community) have tended to cluster in more affluent areas. Just to give one illustration, out of eight urban areas in New Zealand, the less well off Waitakere and Manukau have a considerably lower ratio of GPs per head of population, with average rates of 63 and 70 per 100,000 population respectively. In comparison, the more affluent cities
Auckland and Christchurch have the highest average rates at 104 and 109 respectively (http://www.bigcities.govt.nz/health.htm) Working class city neighbourhoods and economically disadvantaged rural backwaters do not act as magnets to general practitioners who, after all, have their livelihood to consider as well as the well-being of the socially dispossessed.

Furthermore, distance may be a problem: people may have logistical difficulties just physically getting themselves and their families to a doctor. If doctors are in short supply within your own particular territory, you are inclined to ignore or put up with poor health until it becomes so insistently that something really has to be done. By this time, the ‘something’ may have become sufficiently serious as to require hospital treatment. The consequent risk to your own family’s health, as well as the expense to the state health system, could have been avoided by earlier intervention by primary services.

Sociologists refer to this as an instance of ‘perverse incentives’. Poorer people have a negative incentive to postpone seeking early medical help, with the perverse consequence that they end up sicker than they need to be.

Another useful sociological term for this phenomenon is ‘the inverse care law’. Quite simply, those who are in most need of medical services because of their low socio-economic status are least likely to receive them. This is partly because the costs of consulting doctors and buying medication are a strain on already cash-strapped household budgets, and partly because primary health services tend to be thin on the ground in the economically disadvantaged areas where they are most needed. Conversely, people in higher socio-economic brackets have a double advantage. Their comparative prosperity insulates them from the ailments that disproportionately afflict those in poverty, and when their bodies do play up they are better able to get medical and dental treatment, pay the bills, and obtain prompter hospital services.

**Softening class inequalities**

We must be careful not to overstate the inverse care law, however. It does not operate as ruthlessly in New Zealand as in other countries, like Japan and the USA, where many families are left largely on their own to sink or swim. Inequalities generated by the health/class nexus have been considerably softened in New Zealand by benign state intervention.

For a start, hospital treatment has been free to all since the 1930s. True, public hospitals can be impersonal and cumbersome affairs, but the most destitute New Zealand resident is nevertheless entitled to the most expensive **tertiary** (i.e. high tech) surgery. It is part of what is regarded as the ‘New Zealand way of life’. When the National government threatened this in the mid-1990s by introducing user charges in public hospitals, there was such an outcry it quickly backed down. Thus, if people feel they cannot afford doctors’ bills, there is always the state-funded hospital to fall back on (even though over-crowded hospitals do not welcome this expedient).

Public hospitals, though, are only part of the story. When Labour came to power in 1999, it undertook a major reform of the country’s primary health services at the community grass and flax roots. Its **Primary Health Strategy** was intended to reduce the expense to health consumers of medical consultations and prescription charges,
and also to reduce the numbers requiring hospital treatment. It was spearheaded by new Primary Health Organisations (PHOs), which initially targeted the most disadvantaged sections of the population, though they subsequently spread out to cover just about everyone. PHOs were intended to make front-line medical services both more affordable and more congenial. Labour’s health reforms of the early 21st century, in fact, were a return to the social democratic ideal which had inspired the first Labour government to set up free public hospitals.

Thus, although the inverse care principle applies in New Zealand as elsewhere, it is by no means an iron law. While it remains true that health and socio-economic status are related, the worst repercussions of this relationship have been softened by government intervention, most notably with state-funded secondary care in the late 1930s, and state-subsidised primary care after 2000. The underlying class gradient remains fairly steep, but attempts have been made to ameliorate its worst symptoms. That said, the fundamental causal link between SES and sickness has not been broken.

**Poor Health Causes Poverty**

Now for one final point about the nexus between class and health. It is that this is a two-way causal relationship. Poverty makes people particularly vulnerable to illness and injury, but the latter in turn may exercise a downward drag on socio-economic status. It is a two-way relationship: poverty causes ill health; ill health causes poverty.

To take one instance, young people from middle class families are sometimes unaccountably afflicted with severe mental conditions, such as bipolar disorder, just as they are getting qualified and embarking on careers. While their peers begin climbing the ladder that leads to economic prosperity and social status, young folk with mental disorders stay behind, eking out a meager living on a sickness benefit. In another sector of society, sole mothers may find it hard to escape the poverty trap through paid employment, because they are too stressed, exhausted, frazzled or depressed to hold down an outside job. In the former case, a mental disorder pulls middle class people down into the under class. In the latter case, emotional problems hinder people from escaping the gravitational pull of poverty. Either way, poor health is the causal agent, socio-economic status the consequence.

**Industry and Health**

We have just been exploring a widely known sociological principle: class inequalities translate into health inequalities and vice versa. Our focus will now shift from the socio-economic hierarchy to the workings of the industrial economy. By ‘industrial economy’ is meant the zone of society in which men and women labour with tools to extract raw materials from nature, and to process those materials into artifacts of one sort or another, ranging from animal carcasses to electronic messages.

People in the work place are engaged in a non-stop, bodily struggle with inanimate things. They shear sheep, hew coal, heft weights, operate machines, handle chemicals, balance on scaffolding, drive lorries and perform the countless other bodily tasks demanded by the relentless onward thrust of economic life. All these are
potentially dangerous, with serious and even fatal injuries being particularly frequent in sectors like construction, forestry, farming, mining and heavy industry. However, even apparently safe and genteel employment can engender distressing and debilitating injuries through the wear and tear of repetitive strain injury (RSI) caused by the flickering of fingers on a keyboard, the sawing of a violin bow and the like. Furthermore, intensive white collar work can produce psychological damage, as people collapse under the weight of over-work, heavy-handed management practices, chronic anxiety, antagonistic relations with clients and so on. In a word, it is now recognised that **stress** plays a major role in occupational safety and health.

**Accident compensation**
The fact that labour may inflict heavy casualties amongst the industrial army that performs it was acknowledged by the state right at the start of the 20th century, when the first meager Workers’ Compensation Act introduced some small cash recompense to those injured on the job. From 1974, workers ‘compo’ was merged into the much wider Accident Compensation scheme, through which the state provides no-fault insurance cover for all forms of injury, whether on the job or not. To give an idea of the magnitude of the problem, according to the ACC website [www.acc.co.nz](http://www.acc.co.nz), over 33,000 moderate to severe industrial accidents were reported in the year 2000, of which the largest proportion involved back injuries. The economic sphere of society is essential for national prosperity and the individual livelihoods of workers, but it takes a heavy toll on the bodies and minds of those who operate it.

**Downstream casualties**
The injury or illness caused by the productive process extends further than just those directly involved in the labour force, however. Industry can pollute the entire environment through the emission or spillage of harmful substances. These are not only directly toxic to humans, but may also get into the whole food chain, polluting everything from the earth in which crops are grown to the fish and animals people consume. Furthermore, their destructive effects may linger on for many years.

These are termed the ‘downstream’ side effects of industry, and they come in many guises. One major form of environmental contamination of particular concern in New Zealand has been the vast amount of poisonous herbicides and pesticides spread over farms down the decades. They were regarded as essential for the efficient mass production of agricultural commodities on which the country’s economy depended, but were eventually recognised as major health hazards for those consuming those commodities. Even after the use of some of the most dangerous chemicals was discontinued, they remained an environmental risk when leftover stock was dumped.

A controversial case of environmental contamination was the production of dioxin by the firm then called Ivon Watkins-Dow in Taranaki between 1962 and 1985. Local inhabitants claimed they experienced an abnormally high rate of cancer, multiple sclerosis and birth defects through contact with the chemical (though these claims were vigorously denied by a variety of scientific experts). Another was the use of Mapua outside Nelson as a dumping ground for highly toxic chemicals, which were only begun to be disposed of in 2004. Still in 2004, there was a major outcry in Auckland when it was discovered that many homes were built on what was once horticultural land, where a variety of dangerous substances, including DDT, had been used.
Another health hazard came in the form of the asbestos and lead which used to be regularly employed in the construction and painting of buildings, till their health dangers were recognised. People were still trying to get compensation for lung conditions caused by asbestos decades after the damage was done. Although their use was banned, asbestos and lead continued to poison people renovating or demolishing the buildings that contained them.

**Poor Health Undermines Productivity**

Now we shall examine the other side of the coin. If industrial production can undermine health, the reverse is also true. That is, poor health amongst the population at large can have serious negative repercussions for productivity. The industrial injuries discussed above are not only serious for the individuals involved, but can also be a liability for business. This is why the government agencies Occupational Safety and Health (OSH) and ACC devote a great deal of time, thought and energy to the prevention of workplace accidents. They are not just doing this to be nice: accidents put a severe strain both on individual firms and national prosperity generally. It is hard to put a firm figure on how much lost productivity costs the country annually, but it probably runs into billions. One person taking time off to recover from RSI may not matter too much, but it becomes a major economic liability when this is multiplied by injuries in the tens of thousands. Furthermore, the money spent compensating, healing and rehabilitating accident victims could be invested far more productively.

It is not just workplace mishaps that sap national productivity, of course. Equally dysfunctional are all other forms of injury – domestic, sporting and road accidents, and physical and emotional violence – not to mention illnesses caused by disease. We tend to think of these as purely personal misfortunes, but they add up to a major liability for the productive sphere of the economy. This is particularly evident in the depths of winter, when bugs seem to run rampant and people’s resistance is low. Not only do hospitals become over-crowded and their frazzled staff are worked off their feet, but factories and offices are proportionately depopulated.

New Zealand is a comparatively healthy country, and the economy is unlikely to grind to a halt as a result of pandemic illnesses. Even so, there have been times in the past, notably during the polio epidemics that were a national scourge in the first half of the 20th century, when much of the country was shut down by disease. Even today, the disproportionately high rates of physical and mental illness amongst young Polynesian New Zealanders is an economic problem in the making. They are the work force of the future (when other New Zealanders will be retiring in ever greater numbers) but this is a responsibility that poor health may hinder them shouldering.

In the foregoing, four major sociological observations about the relationship between the New Zealand economy and the health of New Zealanders have been outlined and illustrated:

- Socio-economic inequalities generate health inequalities
- Conversely, health status affects socio-economic status
• Economic activity generates health risks

• Conversely, poor health lowers economic productivity.

In the remainder of this section, the economic dimensions of health will be analysed from a different angle. Instead of looking at the New Zealand economy generally, we shall home in on the part of it with particular relevance for our present topic – namely, the medical sector. Using a term introduced near the start, this sector will be termed ‘the medical mode of production’. In modern societies, the treatment of illness and injury has in itself become a vast, multi-billion dollar industry. It is, in fact, an economic system in its own right. By exploring this medical economy, we can cast more sociological light on the processes that lead to positive or negative outcomes for individual consumers, while at the same time deepening our awareness of how sociology contributes to the analysis of economic issues.

The Medical Mode of Production

In September 2004, there was a story line in Shortland Street, New Zealand’s long-running medical soap opera, that neatly encapsulated the various factors involved in what we are terming ‘the medical mode of production’. The head of the hospital’s emergency department knows that patients’ lives are at risk because a piece of diagnostic equipment called a blood gas machine is playing up. Unfortunately, the technology is rather expensive, and the new chief executive officer (CEO) of the hospital, who is working within severe financial restraints imposed by the state-funded District Health Board (DHB), tells the doctor in question he has to sack some of his medical staff to cover the cost of the machine, even though he is already short-staffed. In this one episode, the Shortland Street story-liners encapsulated just about all issues bedeviling the New Zealand medical economy in a nutshell.

At the start of this module, eight ‘factors of production’ were explained, which in combination constitute the mode of production:

• Natural raw materials

• Labour

• Technology

• Capital

• Leadership

• Knowledge

• Consumers

• The State.
These were all at play in the blood gas incident. The raw material being processed was blood. The doctor’s technical knowledge informed him that his consumers’ health was at risk without the purchase of new technology. The capital for this was provided by the state via the DHB, but the hospital’s overall leader knew its funding was not sufficient to cover the costs of both expensive equipment and the wages of his organisation’s labour force. We have already dealt with the natural part of this equation in the previous section, and will explore the roles of consumers and knowledge in later ones. Here, some necessarily brief observations will be made about the five remaining factors of medical production. In particular, the state, capital and labour will be examined, with passing insets about technology and leadership.

**State Funding: The Gap Between Supply and Demand**

As air is to the body, so is money to the economy. Reduce the supply and the system suffers; cut it off altogether and the system dies. It is logical, then, to begin the analysis of the medical mode of production with the cash factor, since just about all issues bedeviling the New Zealand health system flow directly or indirectly from money matters.

The first such issue is so well known, it almost seems unnecessary to say it. Quite simply, there isn’t enough money to go round. Ever more demands are made upon the New Zealand health system. Supply can never keep up. There are a number of reasons for this, including the following:

- Our population is ageing
- There are growing numbers suffering from conditions like diabetes, caused by an unhealthy diet and insufficient exercise
- There has been a resurgence of ‘diseases of poverty’ such as tuberculosis
- People are increasingly demanding medical intervention for conditions like infertility and cosmetic blemishes which were formerly just accepted as part of life.

The medical system is under siege from all sides. People have more and more expectations of what the wonders of modern medicine can do for them. For its part, the health industry has responded to these expectations (and fuelled them further) by developing ever more scientifically sophisticated – and expensive – ways of meeting them. The combination of rising demand for health services, their increased availability, and the rising costs of responding to these creates a growing gulf between what people want and what medicine can provide on the one hand, and on the other what individuals and the nation as a whole can afford.

One symptom is the long waiting lists mentioned earlier for elective surgery in public hospitals. Another is the kind of dilemma facing the *Shortland Street* CEO. When you are strapped for cash, should you spend it on equipment or on staff, when both are equally essential. Furthermore, while hesitating over this decision, another demand is made on your meager purse by the dangerously dilapidated state of your hospital, or
its acute shortage of beds. There is a constant three-way demand on your limited budget – technology vs staff vs an infrastructure of buildings, wards, beds etc.

Even this frustrating dilemma, however, is far less agonising than another form of decision that has to be constantly made by medical executives. Since resources are always limited, services have to be rationed. Who, then, should be given top priority? Should large amounts of money be put into extremely expensive tertiary services (i.e. operations like organ transplants requiring high technology and intensive treatment) that are only provided in a few big city hospitals, and only benefit a small number of people? Alternatively, should the nation’s health budget be spread more evenly amongst much larger numbers requiring cheaper, low-tech interventions like cataract operations?

Dilemmas abound wherever we look. For example, what proportion of the state pharmaceutical funding agency Pharmac’s limited annual budget of around $566 million should go on costly drugs for a comparatively rare condition in New Zealand like HIV/AIDS, as opposed to cheaper drugs for those suffering more common conditions? Or again, Pharmac has to decide the extent to which it should subsidise medication that reduces the statistical probability of a considerable – but unknown – number of people becoming ill in the future. The medication could be wasted on many people, yet crucial for others. A case in point was the cholesterol-reducing drugs called statins, over which there was a major controversy in the 1990s. The National Heart Foundation estimated that statins could potentially protect around 186,000 people from cardio-vascular problems leading to strokes and heart attacks. The cost to Pharmac, however, would have been about $200 million a year. Many other people with pharmaceutical needs would have lost out if doctors had been allowed to prescribe statins freely. Since then, their price has come down significantly, but at the height of the debate around 1997 the statin issue was a classic illustration of the funding dilemma facing the state.

Yet another decision the agency faces is whether to purchase costly brand name drugs or their cheaper generic counterparts, which might perhaps be less effective than the originals but eat up less of its limited budget. Pharmac is often criticised for its choices, but they are all constrained ultimately by something beyond its control – the amount of money it is allocated by the state.

In the early 1990s, the government set up a body to be called the National Health Committee, one of whose original functions was to adjudicate on precisely such questions. In effect, it was supposed to draw up a priority list of conditions for which New Zealanders could expect to receive state-funded treatment. Putting that negatively, it had to decide on criteria for running a rationing system. After wrestling with the matter for a long time, it virtually gave up. The core of its problem was that it was confronting some fundamental ethical issues concerning the value and quality of people’s lives. This issue presented itself in its starkest form in the case of the elderly. Should someone over 80, for instance, have a right to the same expensive treatment, such as a heart transplant, as someone in the prime of life? Alternatively, should we say the old person ‘has had a good innings’ and should now bow out gracefully, thus freeing up scarce medical resources for those with more life ahead of them, and a greater potential contribution to make to the national community?
One way of tackling this issue has been through the calculation of **quality-adjusted life years (QALYs)**. Roughly speaking, these are worked out by estimating how many disability-free years a patient would have left after treatment, then figuring out the cheapest way of generating such QALYs. In this system, human considerations are replaced by arithmetical calculations. These, however, leave out of account some really basic issues about the value of human life. One obvious one is that it is taken for granted that people with disabilities like blindness are less able to live a fulfilling life than others, and it is therefore not worth wasting money giving them life-saving operations. If you were blind yourself, you might see things differently!

The above are just a few quick illustrations of the more general problem confronting the medical economy. Money is finite; health needs are infinite. Since rationing is required, hard choices have to be made. As yet nobody has come up with a satisfactory formula to resolve dilemmas about how decisions should be reached, and by what criteria. Probably the only way to avoid rationing is to become rich enough to purchase medical services privately, but that is not a realistic possibility for the majority of New Zealanders, particularly people whose conditions require expensive drugs or surgery.

**The Private Sector**

While we are on the subject of getting rich, it is important to remember that the invention, development and marketing of medical technology and pharmaceuticals are in themselves industrial activities that can generate great wealth for the firms that undertake them. For consumers and for cash-straitened state providers, things like anti-psychotic drugs and CT scanners are financial liabilities, but for those who produce them they are a source of profit.

New Zealand is only a small backwater for giant, multi-national drug companies, but even so they apply steady marketing pressure here as elsewhere. GPs are regularly bombarded with commercial advertising for a bewildering array of new pharmaceuticals, often accompanied by incentives for them to prescribe the product in question to patients. Doctors cannot possibly check out the merits of every drug, and may therefore be swayed by effective promotional campaigns.

Furthermore, certain medical products, such as pills to reduce weight, enhance virility or combat pain, are directly marketed to consumers via the mass media. Instead of taking advice about medication from their doctors, people are wooed to purchase them through the seductive power of advertising. They then pressure their doctors to prescribe the wonder drug in question. In traditional societies, medicine used to be a cottage industry, where Wise Ones administered potions they had concocted themselves to clients on a one-to-one basis. Since the industrial revolution of the 18th century, like all other aspects of economic production, distribution and consumption, medicines have increasingly become commercial products to be mass produced and mass marketed to the masses. What New Zealanders swallow by way of medication is not necessarily what is best for their health, but for the profit margins of big capitalists.

As well as the giant multi-nationals we have just been discussing, there are many small-scale capitalist entrepreneurs in the medical game. These are health
professionals like doctors, dentists and pathologists who have set up their own practices or bought their way into business partnerships. New Zealand has a mixed medical economy, parts of the work force being paid wages by the state, the other running private businesses which market advice and services in exchange for fees. These are typically small-scale in purely quantitative terms, perhaps operated by just one person, yet can be extremely lucrative. Dentistry, for instance, which on average is the best-paid medical specialism, can earn its practitioners more than the Prime Minister is paid.

The privileged position of private medical practitioners is not due entirely to the value of their specialist expertise. It is in part the outcome of a major power struggle that occurred in the late 1930s and early 1940s between the medical profession and the Labour government of the time. The latter wanted to introduce a full-scale state-funded health system that would be entirely free to the general public. To this end, it was proposed that doctors would, in effect, become salaried government employees, like teachers.

Private medical practitioners strongly opposed such a change to their occupational status, as it would mean a drop in income and also, they felt, in their mana. In 1941, the organised power of the medical profession prevailed, and the government was forced to compromise. We were to have a mixed medical economy – part public, part private. Treatment in public hospitals would be free, but patients would have to pay fees to GPs and other private practitioners. Depending on the government, these fees have been subsidised to a greater or lesser extent by the state. Nevertheless, medical professionals in the private sector retained their privileged socio-economic status, on a par with lawyers and accountants.

The point of this historical digression is to demonstrate the key sociological premise that society is an arena in which power games are constantly at play. Doctors, dentists and the like may be genuinely concerned for their patients’ well-being, and may have rare skills to offer, but their comparatively affluent life style is not entirely the reward for either of these. It is rather the outcome of a determined campaign by private practitioners to resist being reduced to the role of state employees. This was to their advantage, but not self-evidently to that of their patients.

Leadership: Managers vs Professionals

A different kind of power struggle is endemic within the salaried section of the medical profession, particularly those working in hospitals. This is generated by the functional need of all organisations for what, in our list of the factors of production, was termed ‘leadership’, but which will now be called by the more specific terms ‘management’, ‘administration’ or ‘the executive’. Hospitals, along with all other complex bureaucracies, require a top tier of management, like the CEO at Shortland Street, to make and enforce policy decisions, control the budget, hire, fire and discipline personnel, prepare mission statements, write reports, arbitrate disputes and all the other administrative tasks without which the organisation would quickly slide into chaos and bankruptcy.

As we saw in the fictional incident of the blood gas machine, however, managers and the doctors on the ward floor may have different interests and priorities. In the
Shortland Street incident, the former were portrayed as wanting to save money, the latter to save lives. This is just an extreme instance of a more general form of tension that exists in all institutions between managers and professionals. One team’s top priorities are financial prudence and keeping the bureaucratic machine ticking over smoothly, while the other group want to get on with their professional vocation with as much freedom as possible from what they regard as authoritarian intrusion. Executives sometimes think of their professional colleagues as irresponsible mavericks, while the latter can sometimes be heard muttering about ‘little Hitlers’.

Matters are complicated but not eased by the fact that the managerial team often contains doctors and nurses, who have moved into administration as an upward step on the career ladder. These professionals-turned-executives sometimes feel divided against themselves when the external tension between the two sides of the medical system is internalised into their own psyches. They are obliged to exercise authority over their former work mates, but may secretly sympathise with them, and even long to return to hands-on work in the wards.

There is always potential conflict between managers and professionals, but it became a particularly contentious issue during a period of free market reforms to the health system under National between 1993 and 1999. The neo-liberal government was keen to make hospitals operate along the same commercial lines as businesses in the private sector. To this end, they installed career executives (i.e. those with little or no first-hand understanding of health matters) in key positions throughout the health services. Senior medical practitioners, who had previously run hospitals pretty much by themselves, were now playing second fiddle to business executives, who imposed upon them an alien commercial ethos. The wave of managerialism which swept over the New Zealand hospital system in the 1990s highlighted, in an extreme form, a simmering power struggle within all organisations between those whose energies are primarily directed to professional ends – in our case the care of patients – and those who focus on administrative means, which typically entail balancing the budget.

**The Medical Division of Labour: The Case of the Nursing Profession**

The distinction between management and professional staff just mentioned is simply one manifestation of a more general aspect of industrial and post-industrial economies that has attracted the attention of economists and sociologists down the decades. It goes by the rather dull name of ‘the division of labour’, but its social repercussions are far from dull. On the contrary, they give rise to many of the issues that cause tempers to rise and feuds to break out within and between different parts of the medical mode of production. These all have their origins in the practical necessity of dividing the provision of medical services up between different groups of workers, each with their own types of expertise and competence. In what follows, we shall explore the implications of this economic phenomenon for a major sector of the medical labour force – nurses.

The division of labour occurs both horizontally and vertically. By ‘**horizontal**’ is meant job specialisation amongst those working at much the same level of skill, and who are roughly equal in terms of wealth, status and power. Some doctors, for instance, specialise in joints, others in skin complaints, some in psychiatry, and so on, just as nurses, after finishing their general education, may branch off into areas like...
Mental illness, children’s health, the care of cancer patients and the like. With horizontal specialisation, workers are equal but different.

Matters are different with the vertical division of labour. Here, inequalities in socio-economic status are involved.

The medical workforce—like the New Zealand workforce generally—constitutes a hierarchy, with routine, menial labour which almost anyone could perform at the bottom, and tasks requiring a rare level of specialised expertise and responsibility at the top. In purely practical terms, the resulting inequalities are just plain common sense. It would be a waste of scarce human resources for highly trained medical specialists to spend their time bathing patients and emptying bedpans, when these jobs can be done much more cheaply, and just as efficiently, by people with fewer professional qualifications. Conversely, the latter should clearly not be in the business of diagnosing conditions and prescribing treatment, as they lack the expertise.

The hierarchy involves more than just functional task specialisation, however. Wealth, power and prestige are also at stake. The higher you are on the ladder, the more you get paid. Even at the start of their careers, doctors earn considerably more than nurses; when they peak, the difference could run to hundreds of thousands of dollars. Doctors also have more authority. Those at the top of the hierarchy dictate the terms on which those further down must act: the surgeon snaps ‘suction!’ and the theatre nurse jumps to obey. Finally, it is a status ladder: senior medical practitioners and executives command a level of respect not accorded humble careworkers.

The Gender Gap

The medical mode of production, then, generates its own mini class system, with heroic surgeons performing complicated tasks like heart transplants at the top, and humble nurse aids doing routine care work at the bottom. There is more to the vertical division of labour than social class, however. It is also a gender issue, known by the technical term ‘the gender division of labour’. Though the situation is not as extreme today as it was a generation ago, the medical profession is still patriarchal in nature – that is, largely dominated in terms of income, power and status by men.

This patriarchal bias is not because the occupation of doctor today is an all-male one. Over the last quarter-century or so, women have taken up the role in increasing numbers, to the point where over half the graduates from medical schools are now female. Even here, though, it should be noted that men still monopolise the ‘top jobs’, with women tending to disproportionately cluster in the more modest position of GP.

However, where the gender division of labour is really an issue is in the distinction between doctors and nurses. The nursing workforce is overwhelmingly female in composition. Nursing, with its 33,000-strong workforce, is a particularly graphic instance of a more general feature of the labour market. This is that despite feminism, despite female students regularly out-performing their male counterparts, and despite widely disseminated slogans like ‘Girls can do anything’, there are sectors of the economy still designated largely as ‘women’s work’. It is called ‘occupational segregation’. Jobs in which gender segregation occurs include primary school
teachers, shop assistants, telephonists, receptionists, clerical workers, cleaners, textile factory hands, home helps and, of course, nurses.

What these occupations have in common is that in one way or another they are extensions into the paid labour force of tasks traditionally performed by women around the home – caring for children, doing housework, looking after ill or disabled family members, being a helpmate to the male head of household, working with fabrics and so on. What female sectors of the economy also tend to have in common is that they are lower paid than ‘men’s work’, offer fewer career possibilities, are accorded lower status, and the women in them are typically subjected to the supervision and authority of men.

These observations all apply to nursing. Providing domestic care for the ill has always been a largely female domain. Once the nurse role became institutionalised in modern societies as a paid occupation, women were still expected to do the caring, while the curing side of medicine was largely a male prerogative. The job of the nurse was to provide routine back up to the dominant male, whether in the hospital or the private medical practice. Nurses were not only subject to male authority, but were accorded less respect and deference in the status pecking order. Furthermore, they were paid considerably less not only than doctors (which is understandable given the latter’s higher qualifications) but than roughly equivalent male-dominated occupations such as police work.

One justification for the comparatively low pay accorded nursing was that it was thought of as a ‘vocation’ rather than a meal ticket. Females were expected to enter into the nursing vocation with the saintly idealism and selflessness attributed to its founder Florence Nightingale. Middle class women of good character were supposed to dedicate themselves altruistically to the well-being of their patients without mundane considerations about adequate financial recompense. Furthermore, pay was not considered a top priority, since young women were expected to leave their jobs once they got married and had children. If they returned to nursing later, they would have husbands to provide the household with its main income.

Nurses were not expected to do anything so coarse and mercenary as form trade unions to fight for better pay and conditions. Nor were they permitted to challenge doctors on the latters’ own medical grounds. It was felt in many quarters that nursing was not a ‘real’ profession. It was just a ‘semi-profession’. Nurses were caught in a double-bind situation, being viewed simultaneously as high-minded saints and lowly dogs-bodies. Either way, it was deemed inappropriate for them to agitate for better pay and conditions.

**Campaigning for greater pay and respect**

Things started changing in the 1970s. Nurses began a campaign on a number of fronts to have their full professional status recognised, in the triple sense of being accorded higher pay, more respect and greater power to make autonomous decisions. They were engaged, to use a sociological term, in a struggle for collective upward mobility in the labour market. This is conducted today under the aegis of the College of Nurses Aotearoa (NZ), the Nursing Council of New Zealand and the New Zealand Nurses Organisation (NZNO), the latter being the profession’s trade union arm.
The first important turning point for the campaign to convert nursing from a semi-profession to a full one occurred in 1973. Before then, nurses picked up their training on the job in hospital wards. They studied as best they could in-between emptying bed pans and the like. This had the great merit of providing them with plenty of practical, hands-on experience before they graduated, but they did not have a very solid academic grounding in their discipline. From the mid-1970s, this apprenticeship system was replaced by academic education in polytechnics and universities. Like doctors, graduate nurses could put the initials of a degree after their name. More recently, there has been a drive to cast a further mantle of academic respectability over the profession by schemes to encourage nurses to do post-graduate university study.

In part this move from hospital-based training to higher education was motivated by a desire to up-skill the work force and increase nurses’ understanding of an ever more scientifically and technologically complex discipline. At another level, it was done to force more respect for nurses out of grudging doctors. University graduates possess more mana than the semi-skilled manual workers of the old days. Nevertheless, there is still some scepticism, even amongst older nurses themselves, about students who acquire their medical training out of text books rather than practical experience. Furthermore, graduate nurses may be disillusioned when they move from the idealism and theories of a tertiary education environment to the tough, under-staffed and sometimes menial reality of hospital work.

Another important development has been the creation of the role of primary health care nurse. This is part of a broader strategy launched by Health Minister Annette King in 2000 to improve the nation’s health generally through early intervention, the promotion of wellness, the careful monitoring of chronic conditions like diabetes, and the more coherent integration of services. The campaign to actively promote public health is led by Primary Health Organisations (PHOs), that coordinate the community services provided by multi-disciplinary teams, of which primary health care nurses are a key element.

The community nurse as such is not a new concept. Such nurses, for instance, have been the front line of the health system in remote rural areas for many decades. The recent creation of the new primary health care nurse designation, however, has given the occupation a more central role in the public health service. This goes hand-in-hand with the up-skilling mentioned above, since there has been a drive to attract such nurses – particularly rural ones – into post-graduate courses.

An even more recent development in the campaign for professional upward mobility was the creation in 2003 of the new role of nurse practitioner. At the time of writing, there were only 12 nurse practitioners at work in New Zealand, but the position could mark an important stage in the way nursing is practised and perceived. The new nurses are able to conduct diagnoses of serious health conditions, order laboratory tests, prescribe medication and refer patients to hospitals. The nurse practitioner has, in effect, taken over some of the functions of the GP.

A certain amount of controversy surrounds this latest up-grading of the nurse role. On the one hand, it is resisted by some doctors as a form of poaching. All professions tend to guard their territories jealously, and resent intrusions into it, especially when
these are seen as coming from below, as it were. Certain doctors feel uneasy that activities like diagnosing and prescribing, which were once their sole prerogative, can now be performed by those whom they were used to regarding as subordinates. However, some nurses themselves are uneasy about the advent of prescribing nurses. They regard the nurse and the doctor as having distinct, if complementary roles, the one offering care, the other cure. They want the two professions to remain functionally distinct, with nurses providing all-round support services for patients, leaving it to doctors to apply bio-medical remedies. There are thus people on both sides of the professional divide who do not welcome the blurring of the frontier between them.

The three major developments in nursing just mentioned (tertiary education, the creation of the primary health care nurse role and the advent of elite nurse practitioners) do not in themselves address the most basic issue of all – the one that has been at the top of the profession’s agenda for decades. It is, in a word – pay. For a variety of reasons, nurses long felt they were not remunerated in proportion to their qualifications, skill, hard work and contribution to the well-being of the nation. When difficult budgetary choices had to be made between technology, buildings and nurses, the latter often lost out. There were plenty of apparently reasonable justifications, like: “we would love to pay nurses more, but unfortunately all the money has gone on the new blood gas machine”. Recourse was also sometimes made to the Florence Nightingale ideal of nursing as a selfless vocation – something virtuous women did out of dedication to the ill, not pecuniary self-interest. Lurking behind these may have been the unspoken premise discussed earlier – nursing was ‘women’s work’, and as such was automatically downgraded.

Members of the New Zealand Nurses Organisation, on the other hand, felt better pay for their members was a higher priority than machines or bricks and mortar. It was not just a question of having more money to live on – it was also a matter of status. Nurses felt their work was not sufficiently respected. Better pay is a symbolic as well as material form of recognition: it shows your worth is acknowledged. Such lack of acknowledgment is particularly galling if other, male-dominated occupations like the police force get considerably better pay, even though their entrance qualifications may be lower.

Back in 1990, Labour introduced legislation called the Pay Equity Act guaranteeing equal pay for work of equal value. This would have gone a long way to eliminating the pay disparities inherent in the gender division of labour. The Pay Equity Act was repealed by the fourth National government as soon as it got into power later in 1990, but the nurse’s union continued to struggle for the principle ‘equal pay for work of equal value’. In 2004 something approaching it was achieved, although the considerable pay increase of that year still left many in the NZNO unsatisfied. They felt sufficiently strongly on the issue of pay equity that they were prepared to mount a nationwide campaign of industrial action to achieve it. The threat of strike action is a common enough weapon in industrial bargaining for many waged workers, but has been very rarely employed by nurses, partly out of consideration for their patients, partly because the ghost of the vocational image still haunts many members of the nursing profession. For nurses to threaten strike action in 2004 was sufficiently out of character to become a top news story.
In its campaign for better remuneration, the NZNO had a useful demographic ally. New Zealand at the time suffered major shortages of labour power in the medical sector. There were not enough doctors to go around, especially in rural areas and in mental health, and there was an equally acute shortfall in nursing staff.

There were a variety of reasons for these shortages of medical personnel. Working conditions in over-crowded, under-staffed, cash-starved hospitals were often unpleasant. A much wider variety of jobs were opening up to women, many of them offering more pay, status and autonomy than nursing. Qualified nurses frequently went overseas, whether for adventure, experience, better career prospects or to escape the burden of student loan debts. Attracting and retaining qualified nurses thus became a pressing requirement for the New Zealand health system. It tried to import nurses from overseas, and had a considerably higher proportion of such guest workers than other English-speaking countries. However, it was competing for qualified nurses on an international market, and could not match the wages paid by rivals like Britain and the USA. This made life difficult for all concerned, but at least had the positive side effect of strengthening the nursing union’s hand in the industrial bargaining process – even if the very notion of well-bred ladies striking for better pay and conditions would have been anathema to Florence Nightingale.

It has not been our intention to cover all the developments that have occurred in the nursing profession over recent years and the contentious issues surrounding them. We have merely picked out a few representative examples to highlight the more general theme of this section on the economic dimensions of health. Our remarks about the nursing work force – like the preceding ones about the role of medical executives, the financial headaches facing the health system, the nexus between industrialism and illness, and the correlation between health status and socio-economic status – were intended primarily to demonstrate the potential uses to which the analytical framework on which this course is based can be put. We took several core economic concepts, such as class, industrialism and factors of production, and applied them to the specific instance of health. In the process, a number of key themes and issues were explored, all revolving around the two basic sociological premises: social structures affect our health; our health affects social structures. Most importantly of all, we were demonstrating how to set about conducting sociological analysis by using the social map. In the next section, this ‘Beginners Guide to Sociology’ will continue, as we move from economy to demography.
SECTION FOUR: POPULATION

One-off Treatment vs Epidemiology

Medical practitioners working in the front line of the battle against disease deal with its casualties on a case-by-case basis. They tend to be too busy treating individual patients to pay more than passing attention to the progress of the war as a whole. They may be aware there seem to be an abnormally high number of people all coming down with the same condition, and that these tend to be clustered in one particular sector of society, but they have not got the time or resources to study the general pattern, nor to figure out its causes and consequences.

Looking at ‘the big picture’ of disease in the body social overall is the job of statistical experts called epidemiologists. Epidemiology, as its name suggests, is the study of epidemics — that is, outbreaks of an abnormally high number of cases of a particular disease. Two important related terms are endemic and pandemic. The former refers to a disease which becomes entrenched in a population for a long period of time, while a pandemic is an epidemic on the grand scale, affecting millions of people around the world, rather than thousands in just one area.

Another term that will feature prominently in this section is ‘public health’ (also called population-based health). It is the branch of medicine concerned not with the health of specific individuals but the well-being of society as a whole. Public health authorities do not ask ‘How can I cure little Johnny of the whooping cough?’ but ‘How can we protect New Zealand kids generally from getting this illness?’.

People can get confused about the term ‘public health’, as it is sometimes used to refer to all forms of state-funded medical services. Thus, when we talk about ‘the New Zealand public health system’, we may have in mind the government’s funding of hospitals, primary health organisations, pharmaceuticals and so on. This usage is not ‘wrong’ — it is just not how the term public health is being used in the present context. Here, ‘public health’ refers to policies aimed at the wholesale prevention or even eradication of epidemic and endemic disease.

It is a vast topic, and we only have space in the present section to deal with one of its many aspects. This is the public health crusade against what are variously termed infectious, communicable, contagious or transmissible diseases — in a word, those which can be ‘caught’. Our subject in what follows will be the war humanity has been waging since the 19th century against its age-old enemy — infectious disease. As just noted, this war is only one dimension of the broad domain encompassed by the term ‘public health’. It also covers non-catching conditions like injuries and diabetes, but these are dealt with elsewhere in this module. Other dimensions of health demography are also discussed elsewhere. For instance, the correlation between poverty and illness was described in the previous section on Economy, and issues surrounding Māori and women’s health will be explored later in the one on Community.
You will first be given a basic ‘Beginner’s Guide’ to germs, followed by a description of various strategies used to combat them during what will be termed the **heroic age of public health**. We shall conclude by suggesting that humanity’s initial optimism about conquering transmissible diseases has given way in our own time to a more realistic awareness of the limits to medical science, and to a certain scepticism about the grand claims it used to make for its powers. Throughout the discussion, general points will be illustrated with New Zealand examples. These, in turn, will be unpacked to show their significance for the analysis of sociological and philosophical issues.

## A Beginner’s Guide to Bugs

The human population of New Zealand is only around four million. We are vastly outnumbered by an astronomically larger population of invisible enemies. Trillions of them surround us on all sides, and they multiply dangerously inside our own bodies. They are known to science as **micro-organisms** or microbes, to lay people as germs or bugs. They are far too small to be seen with the naked eye, and their precise nature is only known to **microbiologists**. Although some can live out in the open, they tend to be parasitic creatures, colonising larger host organisms, with a particular liking for their digestive tracts.

Many bugs are benign, and can be of considerable use to humans, allowing us to brew beer and cultivate yoghurt amongst many other things. The ones we worry about are those which attack us from within, damaging our tissues or releasing poisonous substances called **toxins**. These bad bugs are known as **pathogens**. We have our own natural defences against them, in the form of the **antibodies** that constitute our **immune system** – a Home Guard which much of the time keeps pathogens at bay. However, if the germs are particularly virulent, or if our immune system is weak (as in the cases of infants, the elderly, the sick and populations never before exposed to the bugs) they can cause serious illness, disability and even death.

Until the 19th century, human societies knew only too well about the consequences of germs, and had even developed moderately effective ways of preventing them from spreading, but they did not know their precise nature. It took the new science of microbiology to develop **the germ theory of disease**. Much of the credit for identifying microbes, figuring out how they operated and inventing protective procedures usually goes to **Louis Pasteur** in the 1860s, although as in all science the discovery of germs was the cumulative work of many scientists before and after him. That said, even if a bit over-simplified it is convenient to think of the formulation of the germ theory of disease in the 1860s as a major turning-point in human history. It inspired scientists and doctors working in the new field of **biomedicine** with the heroic belief that they had gained the power to defeat humanity’s ancient foe – the microbe.

## Varieties, Breeding Grounds and Transmission

Microbiologists classify bugs into different categories. There are tiny **fungi**, such as the one that causes the unpleasant vaginal condition called thrush, and there are little one-celled protozoa, like the giardia amoeba that abound in New Zealand water. The
two best known, though, are **bacteria** (like the germs that cause tooth decay) and **viruses** (such as the flu and the common cold). The former are the bigger of the two, and are the most numerous and prolific of all life forms. Viruses are much smaller – if one was your size, a bacterium would look to it like a dinosaur – but they make up for their size by their invulnerability. Strictly speaking, viruses are not really life forms at all, just ingenious instruction manuals that are able to strip out the DNA of host cells and use it to replicate themselves by the million.

Micro-organisms are everywhere. They have even been found buried in the Antarctic wastes. However, a checklist can be compiled of the places where they present the biggest threat to human beings, and hence where we should be most vigilant.

**Bodies**

All living bodies, human and non-human alike, are thronged with bugs. They settle on the skin, and internally infest our blood, orifices, tissues and intestines. They have an especially nasty habit of getting into wounds and turning them septic. Particularly propitious breeding grounds are provided when many bodies are packed in one place, such as at a party or tangi.

Bugs really have a ball in hospitals, where large numbers of diseased people are herded together. Ironically, we are probably more likely to pick up a bug in hospital – the place we go to be cured – than anywhere else. This is why hospital corridors have that characteristic smell of disinfectant, and why doctors and nurses are so obsessive about ‘scrubbing up’. More gruesomely, infections are spread from the decaying tissue of human corpses. This is why Māori tangi were limited by law to three days. Leading Māori health reformers responsible for this legislation realised that prolonged funeral ceremonies often ended up with many mourners becoming infected by the body of the person they were farewelling.

**Faeces**

In 2001, diners in posh Auckland restaurants came down with gastroenteritis (known by a variety of vulgar terms like ‘the bot’ and ‘the runs’) after eating that expensive delicacy – raw oysters. Sleuth work by health authorities followed the line of causation back to marine farms in the Bay of Islands, and from there to discharges of sewage into the sea, and finally to the intestines of the anonymous Northlanders who excreted that sewage. This is not a very savoury subject, but it graphically illustrates a crucial point about germs. The bacteria in one person’s faeces can end up in another person’s dinner.

Dung is a rather squalid topic to be discussing in polite circles, but every day it comes pouring in enormous volumes from the bottoms of humans, animals, birds, reptiles and insects. Each stool unleashed carries its cargo of expatriate bacteria looking for a new home. Modern human societies have tried to render the ubiquity of excrement invisible by building underground sewers, but this simply shifts the problem from our own backyards to other people’s strip of coastline. It was not so long ago that Wellingtonian surfers used to share the waves with flotillas of bobbing human turds.

**Water**

The third favourite venue for bugs follows on directly from what was just said. It is water. New Zealand reservoirs, swimming pools, hot springs, lakes, rivers and coastal
waters team with parasites like cryptosporidium, giardia and campylobacter. This country’s ‘unspoilt wilderness’ is a major feature in its tourist advertising, but its sparkling waterways have been widely polluted by human waste, often deposited by the tourists themselves when public toilets are in short supply. An even greater source of contamination is our intensive pastoral industry, as sheep and cows cannot be toilet trained.

**Food**

Talking of livestock brings us to the final major source of germs, namely food. We have already touched on it in our story about polluted oysters. Bacteria abound in products like milk, eggs, shellfish and chicken flesh. Microbes can even breed in our own kitchens if food is left around for too long, or when different products get mixed up together in the fridge. Thus, even if the food itself is not contaminated, it can pick up bacteria from the unhygienic conditions under which it is processed.

**How Germs Spread**

Just as there are a number of sites and situations where germs proliferate, so too they have diverse ways of getting inside us – if they are not there already. They all involve infection, but this takes different forms. Highly contagious diseases jump straight from person to person, usually via tiny air-borne globules (one sneeze can spray out a hundred million viruses). This is what happens during epidemics of things like influenza, measles and mumps. With other diseases, the transmission is also person-to-person, but requires more intimate contact, notably through the transference of body fluids – semen, blood and saliva. Sexually-transmitted diseases (STDs), like chlamydia, herpes, gonorrhoea and HIV/AIDS are the most widespread of these. However, human-to-human contagion can occur in less personal ways, as when nurses accidentally infect themselves with contaminated blood, or when patients are given transfusions of blood plasma polluted with hepatitis (as happened to a number of New Zealanders with haemophilia before adequate screening was introduced).

Not all infection occurs between people, however. It can instead be picked up from an outside source. This is frequently the case when wounds of one sort or another turn septic. Alternatively, disease can be ingested from contaminated food or water, or from people being bitten by carrier insects such as fleas and mosquitoes. Once caught, the condition may then be passed on to others, but it is possible to have an epidemic, or for an illness to be endemic, not through human-to-human contact at all, but through many people being infected from the same external source.

**Animal Epidemics**

In a moment, we shall turn from infectious disease itself to ways in which human society has tried to combat it. Before doing so, a final word is needed about illness in non-human species.

Humans share the planet with many other life forms, some wild, some farmed, some domestic. They, like us, can suffer from epidemics, or be infested with endemic conditions. These frequently have major repercussions for human society. No matter
how much humans may vaunt their superiority to other animals, our destinies are
inextricably intertwined with theirs.

The nexus between animal disease and human society is frequently economic.
Simultaneous outbreaks of foot and mouth disease and bovine spongiform
encephalopathy (‘mad cow disease’) did immense harm to British agriculture in the
1990s. The same diseases in New Zealand could cause the country to go bankrupt.
Already, the tuberculosis endemic amongst New Zealand possums gets into cattle,
thereby endangering the country’s beef and dairy industries. The damage does not
end with the economy, however. When society’s economic infrastructure is crippled,
it undermines most other parts of the social superstructure. A full-blown foot and
mouth epidemic in this country could go well towards destroying its entire viability as
a nation.

There is an even more alarming way in which animal infections can impinge upon
humans. This is where bugs jump the animal-human divide. That is, we catch their
diseases. This is probably what happened with the great 1918 Spanish flu pandemic,
which it is believed had its origins in pigs. It is also thought the HIV/AIDS pandemic
began with germs jumping from monkeys to humans. The great fear at the present
time of writing was that the ‘bird flu’ that is ravaging chicken flocks throughout Asia
will fuse with a strain of influenza and cause yet another pandemic against which
humanity will have no immunity.

Thus, although our main subject is human epidemiology, we cannot write an adequate
sociology of infectious diseases without at least a sideways glance at non-human
populations. The wall separating us from other animals can be breached with
devastating ease, either by animal diseases wrecking the economy, or through the
direct invasion of humans by micro-organisms from other species.

Maori Vulnerability

Up to the 19th century, infections and contagious diseases were humanity’s greatest
scourge. Far more soldiers always died of septic wounds and epidemics than were
killed in battle. Entire populations have been wiped out by invading micro-organisms,
and they have caused great civilisations to disintegrate. Even today, whole
populations in poor countries lie thrall to them, notably on the African continent
where HIV/AIDS alone has laid waste the economy, wiped out communities and
engendered personal tragedy on an appalling scale. In case New Zealanders are
tempted to think that all this was either long ago or far away, and that pandemics have
played no significant role in our own history, it might be salutary to remind ourselves
of what happened to Māori people in the wake of their contact with British
civilisation.

Before the advent of Europeans, the whole of Aotearoa was effectively one great
quarantine zone, in which Māori had been sealed off from the outside by vast tracts of
water for the best part of 1000 years. To our present knowledge, their population was
consequently almost entirely devoid of communicable diseases. They were, according
to the reports of the first white explorers, a remarkably healthy people. The downside
of this was that they had virtually no resistance to the hordes of germs with which
Europeans were infested, but against which they had built up defensive armies of
antibodies over the centuries. As Māori and Europeans began interacting with ever
greater intensity from 1769, the indigenous New Zealanders contracted diseases like measles, mumps, influenza, scarlet fever and whooping cough which were not particularly dangerous for European adults but were often fatal for Māori. It was like a shark being let loose in a public swimming pool. Nobody knows the exact figures, but the Māori population had probably been more than halved – mainly by imported diseases – after a century or so of contact with the outside world.

To make matters worse, the casual sexual intercourse that was common in the early days between visiting Europeans and Māori women infected the latter – and subsequently their menfolk – with ‘the pox’ (sexually transmitted disease) which in many cases led to sterility. That is, a people in the process of de-population by one set of diseases was prevented by another from reproducing itself. In the event, of course, predictions that the entire Māori race would die out failed to eventuate, and their numbers began picking up again in the 20th century. Nevertheless, the near-fatal impact that one infected group of people can have on a previously healthy population such as the Māori is essential to emphasise at the outset of our discussion. What happened to the Māori could well happen again to everyone. Indeed, in 2004 the New Zealand government began making emergency plans in the knowledge that a fatal new pandemic not only could erupt, but almost certainly would – but more of that later.

**Public Health Campaigns**

Human societies have always tried to defend themselves against disease. Some of the measures used to be moderately successful, like burning everything that had come in contact with a plague victim, while others, such as performing rituals and offering up sacrifices, had no noticeable effect. It was really only in the 19th century, however, that humanity discovered effective ways of combating the microscopic hordes that infested it. It was then that the modern notion of public or population-based health was born. In fact, we can think of the century or so that runs from around the mid-19th to the mid-20th centuries as a kind of ‘Heroic Age’ of public health, since it was widely believed that the new Western science of micro-biology, combined with medicine into ‘biomedicine’, was triumphantly on its way to stamping out germ-based disease.

As already noted, one of the most important developments was the formulation in the 1860s of the germ theory of disease, but the public health campaign had actually already opened before germs were scientifically identified.

Public health crusaders developed four major strategies over the course of the century in question – segregation, cleanliness, inoculation and antibiotics. Let us look how these were applied in New Zealand from the time of British annexation, which coincidently occurred just as the British were first launching their own war on infection. We shall work through the four strategies in roughly the historical order in which they came on stream, although it must be emphasised that all of them are still regularly practised today.

**Exclusion and Isolation**
The most obvious way to stop diseases spreading is to keep infected people out of your community altogether or else, if they are already in, to isolate them in quarantine. The consequences for a previously healthy population mingling with a disease carrying one was tragically demonstrated in Aotearoa after Māori opened themselves up to Europeans. If they had treated all visitors to the same closed door policy they adopted towards Abel Tasman’s ships, Māori people would have been spared the epidemics that ravaged them throughout the 19th century.

The Māori, however, were not the only ones to whom newcomers posed a threat. Once British colonists began settling in this country, they became conscious that they could themselves fall prey to infections brought by later arrivals from their own countries. Every effort was made by immigration companies to ensure those getting on their ships were in good health, but since most diseases have an incubation period during which the carrier has no symptoms, the screening could never be hole proof. After a voyage out lasting several months, many passengers and crew came down with conditions like measles, mumps, scarlet fever, typhoid and, most frightening of all, smallpox. Ships carrying the latter disease had to display a yellow flag on entering a New Zealand harbour. Health officials would check vessels out on arrival, and possibly order the entire boat load to be placed in quarantine – usually on islands like Motuihe in Auckland and Somes in Wellington, till the danger had passed.

Just how devastating it could be for infected people to slip through the sanitary cordon was shown in 1918, when the ship Niagara brought the so-called Spanish flu to New Zealand at the end of World War I. It was rumoured at the time the ship was allowed to avoid quarantine because it carried the Prime Minister and his deputy (http://www.nzgeographic.co.nz/issue69/influenza.php). Worldwide, the disease claimed more victims than the Great War itself. At home, during four years fighting, around 16,500 Kiwis died, while in four short months around 8,600 New Zealanders succumbed to the flu. The death rate was particularly high amongst Māori communities (around seven times higher than for Pakeha) where the genealogies of entire families were sometimes snuffed out.

Deaths apart, the highly infectious bug disrupted the whole fabric of social life for many months, as people steered clear of one another to avoid catching it. The medical system was quite unable to cope with the crisis, particularly since many doctors and nurses had not yet returned from the war, and those who were here often came down with the flu themselves. At Auckland Hospital alone, 140 out of the 180 nurses caught the flu.

As well as keeping carriers out of the country or in quarantine at the borders, arrangements also have had to be made for victims of internal epidemics of highly infectious conditions. The two most feared of these were probably polio (paralytic poliomyelitis – popularly known as ‘infantile paralysis’) and tuberculosis (TB). Between 1916 and 1961, around 8,000 people contracted polio, many dying and many more again being permanently crippled. Patients could spend months in isolation wards, only able to wave to visitors through the window. TB (often termed ‘consumption’), for its part, was a more or less permanent feature on New Zealand’s medical landscape, although the rate increased considerably during World War I, as a result of soldiers contracting the disease overseas. As with polio, patients had to be
Segregating people with infectious diseases is not an integral part of what was referred to above as ‘the heroic age of bio-medicine’. Society had shunned the ill for centuries, even though knowing nothing of the germ theory of disease. Even so, it merits a place in our round-up of social coping mechanisms, as for earlier generations such segregation was an integral feature of this country’s social life, and still remains the first and last defence against colonisation by bugs. For instance, in 2003, New Zealand immigration services in Asia closed down in face of the SARS epidemic (severe acute respiratory syndrome), while in Canada the city of Toronto was briefly sealed off from the outside world. It is not a great triumph of scientific medicine, but sometimes shutting the door in people’s faces or locking them away is the only protection the healthy have against the ill.

Animals
Keeping diseased populations away from healthy ones is just as important in the non-human as in the human world, of course. Strict quarantine regulations apply to all animals being brought into the country, and species particularly notorious for carrying disease or posing a threat to existing flora and fauna are banned outright. Biosecurity is a top priority for a country like New Zealand that relies for its exports (and the Clean Green brand through which they are marketed) on agricultural commodities.

It is possible to take much more drastic action against infected non-human carriers than human ones. Quite simply, they can be slaughtered en masse. If an epidemic spreads through the farm pigs in a certain area, it will be sealed off and all the herds there killed. Similar extermination campaigns are waged against the TB-carrying possum.

However, mass extermination of diseased populations is often difficult if not impossible, as the case of possums graphically demonstrates.

Furthermore, the mass slaughtering of animals frequently has negative side effects for the human population it is intended to protect. If herds of infected pigs or flocks of diseased chickens are slaughtered, it has devastating economic consequences for individual farmers, and if the culling is widespread, on the economy as a whole. We saw this with the wholesale extermination of sheep and cows in Britain with the epidemics of foot and mouth disease and Bovine Spongiform Encephalopathy in the 1990s, and of chickens in both Asia and Europe in 1997 and again in 2003. The economic impact apart, it can be heart-breaking for farmers to see their livestock butchered, most of it perfectly healthy, as a prophylactic measure.

Public vs Private Good

The requirement for individual farmers to slaughter possibly healthy herds or flocks for the greater good of society generally is worth pausing and reflecting upon. It raises a vexing and probably unsolvable philosophic issue that bedevils all aspects of public health policy – indeed, all discussions of the relationship between society and the individual.

The problem revolves around the term ‘in the public good’.
It is easy to state the issue: what is good for society as a whole may be harmful to individuals, and vice versa. Public health policies address the well-being of the New Zealand population at large. They paint with very broad-brush strokes, dealing in statistical probabilities, not consequences for specific individuals or communities. The latter, in fact, may have to make sacrifices or, more usually, have sacrifices forced upon them. Sometimes these sacrifices are demanded of people who do not directly benefit from them. At the very least, individuals or communities may regard the blanket imposition of public health measures as a blatant infringement of their human rights, whatever the alleged benefits.

Instances occur in every sector of social life where there is a real or perceived conflict of interests between the aggregated good of society on the one hand, and the well-being, rights and values of specific individuals on the other. It can be seen, just to give a few representative examples, in controversies over the fluoridation of drinking water, the discharge of sewage, taxes on the emission of greenhouse gases, mass vaccination, anti-smoking legislation, and the criminalisation of marijuana. The same issue is involved in the matters of exclusion and quarantine discussed above, where some people, who may well be germ-free, are denied the right to move around freely. In these and many other cases, public health measures are imposed on the entire population for its own good. However, what is good for ‘us’ in general may not be good for ‘me’ in particular.

The dilemma sometimes takes the opposite form to the one just mentioned. Instead of a few people suffering for the cause of the greater public good, many people may be disadvantaged because of a perceived threat to a tiny minority. In 2004, for instance, anti-depressants, which had been regularly prescribed for many years to help young people with mental disorders, were suddenly pulled off the market because in a statistically small number of cases they increased the risk of suicidal thoughts. Doctors were abruptly denied an important weapon in the fight against youth depression. This was just one specific instance of a wider phenomenon – denying many people perfectly safe treatment as a precautionary measure against the few who suffer adverse reactions. In a different form, this raises the same vexed issue that was raised above. How do we balance the rights and values of individuals with the well-being of entire social categories?

However, we are sidetracking a little from our central topic – the ways in which humanity has defended itself against disease. Putting people in quarantine is not the only line of defence. Let’s now move on to a second one.

**Hygiene and the Condom Controversy**

The second defensive tactic against germs is more characteristically modern than isolation, since it has been systematically practised only from the 19th century. Even so, it is not really ‘bio-medical’, since it was known about before the germ theory of disease came on stream, and does not really require a great deal of scientific sophistication to understand and practice. It can be summed up in the one word ‘cleanliness’.
The first major inroads into the epidemics which were once the scourge of humanity were made in the 19th century when it began to dawn on people through empirical observation that there was a connection between insanitary practices and the spread of disease. The discovery of micro-organisms simply confirmed and explained the connection, reinforced the need for better public and personal hygiene, and suggested ways and places where it could be systematically practised.

The great problem with micro-organisms, of course, is that by definition they are invisible to the naked eye, so we cannot see them on our hands, on the surface of household objects, floating in water, infesting food and so on. Once alerted to their existence, though, they can be kept at bay simply by the sanitary disposal of faeces and the vigorous application of soap and water, backed up by liberally sloshing disinfectants and antiseptics around.

Thus, plain personal cleanliness is all that is often needed.

However, where germs abound on the grand scale, individual hygiene needs to be complemented by public health measures on the part of central or local government. Four examples of such front-line strategies are the chlorination and filtration of drinking water and swimming pools, the treatment of raw sewage, the fluoridation of town water, and pasteurisation – that is, the heating of milk to destroy bacteria. In such cases, hygiene has to be practised wholesale, since individuals sanitation on its own cannot defeat the massed enemy troops.

Although cleanliness is an essential component of the war against bugs, it is not a theme on which we need to elaborate at length, since the necessity for it is something that is now widely known. We have probably all, for instance, been nagged by our parents to clean our teeth after meals to keep Bertie Germ at bay, and to wash our hands after going to the lavatory. However, there is one particular aspect of hygiene which merits a mention in its own right, partly because it involves the story of a heroic New Zealander, partly because it shows the nexus between personal and public health, and partly because it raises another of those key issues in which sociologists are interested. It all revolves around the humble condom.

**The condom crusade**

As we all know, condoms serve the double function of guarding against pregnancy and preventing the spread of STDs. Protective sheaths of one sort or another have been around for a long time, but only came into wide use in the first part of the 20th century, mainly in response to the rampant sexual promiscuity that accompanied World War I.

A New Zealander called Ettie Rout was a major campaigner in the invisible war against venereal diseases (as they were then called) that was being waged in the bedrooms and brothels of France and the Middle East while soldiers were killing one another at the front. Largely to protect women back home in New Zealand and Australia from being infected by the diseases that their men were exposed to while overseas, Ettie Rout took it upon herself to launch an educational crusade amongst the ANZAC troops to persuade them to take precautions when wallowing in the fleshpots of Cairo, Paris, London or wherever. It culminated with them being regularly issued with prophylactic kits before going on leave.
This was a daring and controversial innovation at the time, as it openly acknowledged that young men away from home indulged in sexual intercourse. Although she did an enormous service for New Zealand women by protecting them from the bugs the boys brought home, Ettie was widely reviled by their organisations, and also by the churches, for violating moral taboos surrounding sex. Puritan morality back then, as it still does today, maintained only one form of sexual activity could be condoned – heterosexual intercourse within marriage. Advising young people to be sexually hygienic by using condoms was tantamount to encouraging promiscuity.

The condom controversy erupted again in a new and more intense form when AIDS made its first appearance in New Zealand around 1983, and the deadly epidemic began taking its toll on the gay community. The subsequent ‘safe sex’ public health campaign was in some ways a re-run of the crusade Ettie Rout had conducted some 70 years earlier. In acknowledgment of her pioneer work, the Christchurch AIDS Foundation named its headquarters the Ettie Rout Centre.

We mention Ettie Rout’s work during the Great War because it puts an interesting New Zealand face to the global public health issue of sexually transmitted diseases – a war which has taken on even greater significance since the advent of AIDS. More importantly, the widespread hostility Rout encountered in conservative circles highlights a core issue that still bedevils public health initiatives. Health reformers sometimes walk into moral and religious minefields, particularly where sex is concerned.

To promote safe sex, it has to be recognised that people have sex in the first place. Those with conservative views on morality are reluctant to do this, as they feel that recognition implies acceptance. Promoting the use of condoms, they argue, encourages young people to indulge in sexual intercourse, an activity which is even more morally reprehensible if it occurs between men. It is preferable to vigorously promote pre-marital celibacy, marital fidelity and universal heterosexuality. Telling people about the benefits of condoms just encourages them to be sinful.

Today, as in Rout’s time, New Zealanders are deeply divided over something so basic as whether it is acceptable to promote sexual hygiene. In this as in other areas, the very grounds on which public health policies are based are heatedly contested.

**Immunisation**

Two ways of avoiding infection have now been covered. First, keep diseased people at a distance and slaughter diseased animals. Second, practise personal hygiene and treat sources of potential contamination. Now a third prong of the epic war that was declared on disease in the 19th century will be introduced. Like the use of quarantining and the promotion of good sanitation, it actually began before the role of micro-organisms in spreading disease was fully understood, but its efficacy was greatly enhanced once scientists cracked the mystery of the microbe around the 1860s. It involves what is variously termed **immunisation, inoculation** and **vaccination**. (The terms actually refer to different procedures, but tend in everyday speech to be used interchangeably.)
It works by strengthening people’s own powers of resistance to disease. Their home
guard troops of antibodies are put on alert by being exposed to comparatively safe
versions of dangerous diseases. The body’s immune system rallies to fight off the
simulated invasion, and thereby strengthens its defences against the real thing.

It was already known in Britain how to do this when New Zealand was first settled,
and missionaries began immunising Māori against smallpox as early as the 1840s. By
1863, a Vaccination Act was in place, requiring all young children to be inoculated.
Ever since, mass immunisation of children against a package of diseases like measles,
mumps and rubella (MMR) has been a standard feature of public health in New
Zealand. People with high known risks of other diseases, like TB, tetanus and various
strands of hepatitis, are targeted specifically for these conditions. The result has been
that many once virulent epidemics have been either eliminated, or else had their scope
and intensity greatly reduced.

One of the biggest vaccination success stories concerns polio, whose crippling
epidemics featured so prominently in New Zealand social history for the first half of
the 20th century. They were virtually stopped dead in their tracks between the mid-
1950s and mid-1960s by the Salk and the Sabin vaccines. Today, polio has been
virtually eradicated by these vaccines worldwide.

However, biomedical science has to be constantly vigilant, as new strains of infection
against which people are not yet immune, including constant variations on the flu
theme, keep coming on stream, making it necessary to continue discovering,
manufacturing and delivering new vaccines. A case in point was the New Zealand
government’s decision in 2002 to invest around $200 million in research to discover a
vaccine against a local form of meningococcal B disease that could result in death or
serious disability. There had been an epidemic of this disease since 1991, affecting
around 5,000 people. It was particularly dangerous for infants and young people, and
took a disproportionately high toll amongst Māori and Pacific islanders. Once the
vaccine was developed, in mid-2004 a programme of mass vaccination was launched,
beginning in places like Manukau City where the prevalence was particularly high.
There are some conditions, however, for which vaccines have not as yet been
developed, including two of the world’s top killers – AIDS and cancer.

Opposition to immunization
As with other aspects of the public health war against communicable disease,
immunisation has met with strong resistance in some quarters from the time
vaccinations against smallpox first began right up to the present. In some cases this
resistance is systematic and organised, operating out of groups like the Immunisation
Awareness Society. They insist that there is empirical evidence proving that
inoculation can be harmful, infecting people with full-blown cases of the very
diseases against which they were seeking protection. The anti-immunisation lobby
also argues that vaccination has been more or less irrelevant in the fight against
epidemics, as these were already on their way out thanks to better diet, improved
sanitation and increased natural immunity. Mass immunisation is thus unnecessary at
best, dangerous at worst, its opponents argue.

Whether right or wrong, such opposition to vaccination is carefully reasoned and
based upon allegedly scientific evidence. There are other people, however, who are
not so much actively opposed to vaccination as lazy, careless or indifferent. There is no sign of the disease in question being around, so parents see no point in having their children protected. A case in point was an outbreak of whooping cough in Christchurch in 2004, mainly as the consequence of infants not being given a jab of the relevant vaccine.

Here, then, we hit yet another of those issues which are as endemic in the public health world as are the diseases it tries to combat. Whatever measures are proposed, there is always resistance. Sometimes it is based on science, sometimes on morality, sometimes on religion, sometimes on the defence of individual rights, and sometimes on just plain laziness.

It must also be acknowledged that on occasions antagonism towards inoculation, as to other public health practices, stems from far-fetched, even paranoid conspiracy theories. Religious leaders in Nigeria, for instance, claimed that anti-polio vaccination was a Western plot to make Moslems sterile. New Zealanders are also not always immune from conspiracy theories. They abounded, for instance, when fluoride began to be put into town drinking water in the 1960s. Thus, while opposition to inoculation and other population-based health practices is sometimes based upon sincere principles, it may on occasions be tainted with fanaticism, or at least marked eccentricity.

**Antibiotics**

The crowning triumph of the heroic age of biomedicine was the discovery and widespread use from World War II of antibiotics – that is, human-friendly bugs that can kill toxic ones. The main credit for the discovery went to the British scientist Alexander Fleming who cultivated the wonder drug penicillin (which he originally grew on bits of mouldy bread). Medical practitioners had previously been aware that some substances were effective at cleaning up infections, but they had not fully understood how, and more importantly were not able to isolate and to mass produce them.

It was the ability to create penicillin and other antibiotics synthetically, rather than relying on naturally occurring mould, that was the real break-through, as it was then possible to make them available worldwide. Since then, bugs which slipped through the three lines of defence discussed above – quarantine, hygiene and inoculation – could be directly targeted and destroyed inside their host’s body. Countless people suffering from infections, who in all earlier ages would have died or remained permanently ill, have been restored to health by the new wonder drugs. It looked as though humanity had discovered the magic bullet.

However, there is one major weakness in the antibiotic line of defence against germs. They are only effective against bacteria. The smaller and sometimes deadlier viruses are invulnerable to antibiotics. This is because they are not really life forms at all, just noxious little bits of information-processing matter that get inside living cells and use them for their own ends. Thus, prescribing antibiotics for diseases caused by viruses is pointless – something of which many people seeking medical miracles are unaware. Admittedly there are antiviral drugs in the biomedical arsenal, such as the cocktails used to stave off the inroads of HIV/AIDS, but these tend to be expensive,
they are in comparatively short supply, and they typically provide only a rear-guard line of defence.

**The Bugs Fight Back**

As a result of the combined effectiveness of the four strategies outlined above, by the mid-20th century there was a mood of self-congratulatory triumph in scientific and medical circles. Humanity began telling itself a new **master narrative** – that is to say, an all-encompassing story about how the world works and the place of human beings in that world. In the old days, the reigning master narrative had been religious: human destiny was in the hands of supernatural forces. This was replaced in the modern age by a secular belief in progress through applied science. The manifestation of this new faith in scientific progress most relevant to our present discussion was our species’ apparent victory over disease, thanks mainly to the discoveries of microbiology, and to the capacity of the new industrial economy to make these globally available.

By the 1960s, germs were apparently being routed on all fronts. Some diseases, like polio and smallpox, were on their way to extinction. Others became rare where once they were common. Others again lost their former virulence – they became inconvenient rather than life-threatening. The common-or-garden bacterial infections that had once been the bane of medicine – the frightening way they could turn even minor cuts and abrasions septic, and thereby poison the entire system – could be quickly knocked on the head with an injection or course of pills. So, too, could STDs, which remained unpleasant and humiliating, but easily curable.

All in all, humanity seemed on the threshold of a new Golden Age. This was thanks not to religion and magic but to the enlightenment of biomedicine. Indeed, medicine became something of a new, secular religion, of which the high priests were microbiologists and the doctors who administered their discoveries. Because of its apparent success in the war against disease, the bio-medical establishment gained a position of **hegemony** – that is, total dominance – over people’s minds and bodies. It appeared to hold human destiny in its healing hands. The wealth, power and mana of scientific medicine rose accordingly.

That, however, was a generation or so ago. If we look around New Zealand today, we might feel less optimistic about the liberating potential of scientific medicine than we did back in the 1960s. True, germ-borne disease and infection is much less of a public health hazard to New Zealanders at the dawn of the 21st century than it was at the outset of the 20th. Nevertheless, less progress has been made than was hoped in the Golden Age of biomedicine, old problems have resurfaced, and lethal new dangers have emerged. Our confidence in the new religion of science has been shaken.

Let us go back over the four lines of defence against infectious disease discussed above, and briefly note how each has either been breached over the last few decades, or could be breached any time in the near future.

**Exclusion and Isolation Revisited**
The rate and speed of global travel has increased immensely since the 1950s. At any
given time, New Zealand has almost as many overseas visitors within its shores as
permanent residents. All diseases have an incubation period, during which their hosts
may be already infectious but show no external symptoms. No matter how
assiduously in-coming travelers are screened, there is no possibility of ensuring that
carriers of infectious diseases do not slip through the net. The dangers are particularly
high if the country where the disease originated did not put out an instant worldwide
alert, as happened at the outset of the SARS epidemic in 2003. Even in the old days
of sea travel, the Spanish flu of 1918 had no difficulty getting into New Zealand and
devastating its inhabitants. In 2004, The Ministry of Health put into place a
nationwide contingency plan against the outbreak of a new killer pandemic of
influenza or other diseases. Such planning is done on the realistic assumption that if
such a calamity occurs somewhere else in the world, it will almost inevitably arrive
here by plane in a very short space of time.

Our defences against non-human diseases that could destroy our agricultural base are
just as precarious. In 2000, for instance, a little mite called varroa sneaked into the
country and began wreaking havoc amongst bees. The outbreak started in just one
North Island district, and strenuous attempts were made to keep it there. These were
unsuccessful, however, and now apiaries throughout the whole North Island are under
siege, and the South Island is keeping its fingers crossed. Bee mites yesterday... foot
and mouth tomorrow? It happened in Britain, and it could happen here.

Hygiene Again

One half of our national logo ‘Clean and Green’ boldly proclaims New Zealand’s
cleanliness. In public health terms, it is hard to find evidence for this. On the contrary,
when compared with other OECD countries, notably our Australian cousins, the Kiwi
appears to be a rather dirty little bird. Here are just three instances to suggest that if
good public and personal hygiene is the frontline defence against disease, this country
is significantly in the rear.

According to a story in the NZ Herald on 25/9/2004, the rate of food poisoning in
New Zealand, particularly from campylobacter, is the highest in the developed world –
five times higher than Australia, and ten times higher than Canada. The microbe is
widespread in our waters, but mainly gets into our diet through contaminated
chickens and shellfish. There were 14,786 reported cases of campylobacter poisoning
in 2003 alone, and this was an 18% increase on the previous year. Food poisoning
cost the country an estimated $55 million that year in things like days off work and
medical expenses.

The New Zealand Food Safety Authority was created in 2002 from a merger of the
functions of the Ministries of Health and of Agriculture and Forestry to launch an
integrated crusade to clean up the country’s food. To this end, in 2004 a five year
survey of food producers and processors was begun. Though these are positive
initiatives, the very fact that they had to be undertaken at all suggests the endemically
poor quality of this country’s food hygiene. This is particularly remarkable in a nation
whose economy is based on primary production.
Another matter of current concern is water-borne illness, such as that caused by cryptosporidium. Although people have known for over a century about the importance of clean water, levels of contamination here are significantly higher than in other developed countries, particularly of the drinking water in smaller districts. In acknowledgment of this problem, in 2004 the Drinking Water Amendment Bill was introduced, proposing another five-year plan of action, this time to clean up the country’s water. What is surprising is that although the importance of elementary forms of food and water sanitation were understood in this country back in the 19th century, it is not proposed to have universally hygienic food and water till around 2009.

Carelessness over hygiene occurs at a more intimate level as well. Despite the public education campaigns to promote safe sex that have been vigorously conducted since the 1980s in this country, young people’s use of condoms today lags behind their counterparts overseas. One indicator is the rise in the prevalence of STDs in the early 21st century, notably chlamydia. A straw in the wind in this respect was a sub-plot of Shortland Street in 2004 that highlighted the spread of this disease among the young, and gave the viewers a nudge in the ribs about the dangers of unprotected sex. The story-liners for this soap opera are not social scientists, but they have established a reputation down the years for spotting and publicising important social issues. In this case, their chlamydia story was fiction, but it was referring to empirical reality. Between 1999 and 2004, the rates of both chlamydia and of gonorrhoea increased by 65%, with 4,485 cases of the former condition diagnosed in sexual health clinics in 2003. The incidence of such STDs, and also their rate of increase, are far higher here than in Australia, and can only be accounted for by a reluctance amongst many young New Zealanders to use condoms. The same reluctance has also resulted in this country having the highest rate of pregnancies amongst unwed teenagers in the developed world. It was to combat these negative statistics that the Ministry of Health launched the ‘No Rubba, No Hubba Hubba’ campaign in 2004 to promote condom use.

The upshot of the foregoing is that New Zealand is at the bottom of the league table in three very elementary dimensions of public health – safe food, water and sex.

Vaccination Again

Although mass immunisation against disease has in many ways been a success story, there are still holes in the safety net. It has already been mentioned that some people are opposed to inoculation and that others cannot be bothered. We also know that vaccination against today’s worst killers, notably AIDS and cancer, is still not possible. Those problems apart, new diseases, or new variations on old ones, come on stream so fast it is hard for public health authorities to keep up. Just about every winter, peaking in July, New Zealand is infested by another flu virus against which we have not developed immunity. There is usually only enough vaccine for the very young and the very old, and for people working in the medical front line. The situation will be much worse when the Big One hits – that is, the massive worldwide pandemic of influenza, possibly laced with another toxic virus such as swine flu.

New Zealand, along with other Western countries, is already beginning to stockpile vaccines and antivirals in case of a global pandemic, but such precautionary measures
are hindered at the outset by the fact that the authorities do not know what form the disease will take. When they do, by the time a vaccination and/or antiviral drug is discovered and manufactured, it may be too late for many. The economic factor also has to be taken into account. The drugs will be expensive for individual consumers if a user-pays system is operated, while their free distribution to the population generally would put an enormous strain on the limited resources of a small country like New Zealand. This talk of a new pandemic may appear excessively melodramatic, were it not for the fact that at the beginning of the 20th century the world lost millions to the Spanish flu, and at the end began losing millions more to AIDS. Inoculation is unquestionably a strong line of defence, but it is by no means impregnable.

Still in the domain where melodrama and cold reality rub shoulders, it must be remembered that germs stand alongside nuclear and chemical weapons in arsenals of mass destruction. Many countries, such as the United States, have possessed disease arsenals for decades, but the risk of germ warfare has probably increased since the world moved from the epoch of the Cold War to that of micro terrorism. Terrorist cells, indeed, are very much akin to viruses within the body social, but this affinity may become literal rather than metaphorical if they are able to release microscopic pathogens amongst the general populace. The emergency planning that is already under way against a possible pandemic in the near future is as much motivated by the fear of bioterrorism as by the 2003 outbreaks of SARS and avian flu.

**Antibiotics again**

To complete this depressing litany, the last lines of defence against infection – that is, antibiotics – have started to lose their apparently magic power. The silver bullets are missing their targets or bouncing off. On the one hand, bacteria have often grown resistant to antibiotics through excessive exposure to them. This is because doctors have prescribed them far too liberally, but may also in part be due to the fact that battery-farmed chickens are saturated in antibiotics, which eventually end up in human beings. As well, because bacteria multiply in the billions, they can quickly produce mutant strains that are bulletproof. As quickly as new antibiotics are invented, the bugs re-invent themselves. They seem particularly adept at doing this in the very places where they are most dangerous – that is to say hospitals. These are breeding grounds for antibiotic-resistant **superbugs** affecting patients and staff alike. The irony is that the more we use antibiotics, the less effective they become.

The upshot is that public health officials are becoming alarmed at the prospect of a world in which antibiotics are increasingly ineffective. In the wake of Alexander Fleming’s discovery of penicillin, and his colleagues’ discovery of how to synthesise it, a sense of euphoria swept through the medical establishment. It had the power to out-god God. A jab of a needle could fix everything from war wounds to the clap.

Today, that euphoria has been replaced by growing disquiet about new generations of mutant superbugs to whom the needle is no longer a threat.

**Diseases of Poverty**

Now for one final reason why New Zealanders today are less optimistic about the eradication of disease than they were back in the 1960s. One of the main causes for
the reduction of disease during the ‘heroic age’ of medicine actually had nothing whatsoever to do with medical science itself. It was due, rather, to the gradual improvement in the general living standards of the New Zealand population. Especially after the advent of the Welfare State and post-war prosperity, New Zealanders ate and were housed better, while full employment provided secure household incomes. Since poverty tends to breed disease, as the former is rolled back, so is the latter. The wonders of modern biomedicine were often given the credit, but the improvement might have come about, in part at least, more or less of its own accord. You cannot quantify these things exactly, but it is possible that up to 80% of the improvement in general health is due to improved living standards, leaving only around 20% for which medicine can take the credit.

The negative corollary, however, was that when poverty again began making its presence felt after the 1973 economic downturn, and was arguably aggravated by the New Right policies of Roger Douglas and Ruth Richardson, the diseases of poverty re-surfaced. The socially disadvantaged – amongst whom Māori and Pacific Islanders were over-represented – began to suffer from conditions like TB and rheumatic fever which doctors had thought virtually things of the past. Ostensibly a ‘first world’ country, New Zealand found itself harbouring ‘third world’ diseases, triggered by factors like inadequate food and poor, overcrowded housing. It did so, moreover, at a significantly higher rate than other OECD countries, including Australia.

The End of an Era?

The upshot of all the above is that the heroic age of biomedicine is over. By this is not meant that medical science has ceased making inroads into transmissible diseases and infections. On the contrary, the war goes on, new battles are still won, and strategies are in place both to mop up old enemies, like food poisoning, and to confront fresh ones, such as swine flu. When we say the heroic age is over, we mean only that people’s faith in scientific medicine is not as absolute as it was a generation ago. Back around the 1960s, most New Zealanders were true believers in the secular salvation offered by the scientists and doctors who were the high priests of biomedicine. Today, the experts’ confidence in themselves has been shaken, and lay consumers have turned agnostic. Most still want to believe that medicine can perform miracles, but our faith has been undermined. We are therefore less inclined to accord medical specialists the unquestioning acceptance and respect they once received. Biomedicine is still a master narrative, but its authority has been challenged.

In some circles, such as religious fundamentalists or alternative healers, this weakening of the absolute authority of science has been welcomed, as it increases the legitimacy of their alternative worldview. For many others, the realisation that the power of medical science is severely circumscribed is just plain frightening.
We shall now close our exploration of the social significance of communicable disease. Disease itself, however, will remain in the foreground of our minds as we move from the demographic to the political sphere of the social map. In the next section, our attention will shift from the transmissible infections that have been our subject in the foregoing to the non-transmissible ones that are the targets of a new approach to public health in the 21st century.
SECTION FIVE: THE STATE

We have now arrived right in the middle of the social map. From its strategic central position, the octopus of government extends its tentacles into all the other spheres from nature right through to culture. Indeed, we have already encountered some of those tentacles in previous sections. For instance, in our discussion of the economy we saw the state agencies ACC and OSH at work promoting industrial safety, while in the Population section, government was shown to be a key player in the public health game. The influence of Government is felt in all sectors of society, and it has therefore not been possible to keep it contained tidily in just one part of our analytical framework.

Bearing in mind that the state thus puts on important appearances elsewhere in the module, in the present section five major themes will be addressed. First, this country’s ‘mixed economy’ of health provisions will be briefly described. Second, the main features of the state health system’s structure and functions will be outlined. The third part will be devoted to a historical sketch of major policy changes in governmental provisions of health services from the grudging charity of the 19th century to the primary health care revolution of the early 21st. We shall then return to the discussion of public health we began in the Population section by describing the new form that the crusade against population-based disease has taken in recent decades. Finally, you will be introduced to the philosophical issue of determinism and free will, or structure and agency, which has vexed the minds of philosophers down the ages, and you will be shown its significance for New Zealand health reforms since the 1980s.

The Mixed Economy: State and Civil Society

Although the government is undoubtedly a dominant actor on the health scene, it does not have the action to itself by any means. It shares the stage with the players from two other spheres of the social map – private enterprise and the voluntary (or not for profit) sector. Those two constitute what is termed ‘civil society’, a term which covers everything outside the orbit of government. We thus have what is termed a ‘mixed economy’ of health provisions. Our main focus in the present section will be on the state, but before getting on to that, a brief description of the other two players in the mixed economy will be given here, just to remind ourselves that the state does not have a monopoly on the provision of health funding, services and goods.

Private Enterprise

As was explained in the Economy section, the New Zealand health system has a large private sector operating on commercial lines. Though sometimes motivated in part by a genuine desire to do good, private entrepreneurs mainly get into the health game, as they do into all business ventures, to generate profits in the market place. This is why, to give just a few examples, health insurance companies are established, pharmaceutical corporations develop and market drugs, medical practitioners set up in private practice, pharmacists run chemist shops, people operate rest homes and home help agencies, and a myriad of alternative therapists market herbs, diet
supplements, homoeopathy, aromas, crystals and the like. Sooner or later, all New Zealanders need curing or caring. It is a sector of the economy where demand always outstrips supply, and demand itself will increase as the New Zealand population ages. Poor health makes for healthy business.

Until about the mid-20th century, and in many countries still, people in need of specialist medical goods and services either bought them privately or went without. In New Zealand today, the ruthlessness of the market place has been considerably softened by state intervention. This helps close the gap between consumers and producers, thus ensuring that medical provisions are made on the basis of need, not just the ability to pay. That said, the private sector of the health economy still has many major roles to play, from the invention of therapeutic drugs to the provision of nursing care for the elderly, which government either cannot or will not perform. Take commercialism out of the equation, and the New Zealand health system would collapse.

The Voluntary, Not-for-profit Sector

A similar collapse would occur if what is termed the voluntary or not-for-profit sector shrugged off the major responsibilities for health care it has always shouldered. What distinguishes activities in this sector is that they are done privately (as opposed to being state-provided) but they are not undertaken to generate profits, as with the commercial sector. Broadly speaking, the voluntary sector can be thought of as comprising four tiers:

- **Non-governmental organisations (NGOs):**
  A health NGO is a privately run community group set up to provide goods, services, support, public education and/or advocacy in connection with a specific area of health. Some NGO workers are paid, some are unpaid volunteers. They may be subsidised by the state, but rely heavily on bequests, business sponsorship and donations from the general public. Examples include St. John Ambulance, rescue helicopters, hospices, and a wide variety of other trusts, incorporated societies and the like, such as the Foundations for Breast Cancer, Mental Health and the Starship hospital, as well as an increasing number of urban or iwi Māori health organisations.

- **The general public:**
  As just noted, NGOs depend heavily on the generosity of the general public during appeal campaigns for their particular charity, such as Daffodil Day for the Cancer Society. Without support from *the charity dollar*, many would go out of business.

- **Self-advocacy groups:**
  There are an increasing number of organisations run by and for health ‘consumers’ or ‘users’ (once called ‘patients’). Some may provide a limited range of goods and services for their members, but they are not primarily service organisations. Rather, they are formed for mutual support and protection, and to promote the interests of consumers against what they perceive to be the oppressive tendencies within the mainstream health establishment. Examples are the various groups involved in the women’s health movement that began in New Zealand in the 1970s, and the more recent Psychiatric Survivors network that was launched in New Zealand in the 1980s.
• **Families and friends:**
  In the first and last instance, New Zealanders today, like people in all previous ages, depend upon their families and close friends for care when they are ill or injured. If anything, this dependence has increased since the 1970s, as a result of the deinstitutionalisation movement, which has seen a concerted drive to push people from long-stay hospitals into community care. When the term ‘community’ is used in this context, it usually refers to families. Furthermore, it tends to be women who are expected to take on the main responsibility for nursing ill or injured family members. Thus, now as always, the front line of health care is provided by unpaid daughters, female partners and mothers.

**Social capital**
The four elements of the voluntary sector taken together provide what it is fashionable in some circles to term **social capital.** This is a rather cold, commercial expression, but basically it means a community’s ability and willingness to rally around and help its members when they are in need. The higher the level of social capital in civil society, the less necessity there will be for state intervention. Indeed, there is a broad general correlation between social capital and health: roughly speaking, the more cohesive a community, the healthier its members.

We shall leave our discussion of the community’s input into health care aside for the moment, to be picked up again in a later section. The purpose of the foregoing was simply to remind ourselves that in a mixed health economy like New Zealand’s, three sectors are at work – the state, commercial, and not-for-profit. Government could not possibly attend to all our health needs on its own. Take away the last two, and our health system would be in tatters. Having established that crucial point, we shall now devote the rest of this discussion to the state – also known as **the public sector** – beginning with a quick round up of its major structures and functions.

**The State Health System**

This part will provide a short sketch of the anatomy and physiology of the governmental health octopus. We shall keep the description fairly minimal, just bringing out a few of the most important structural and functional features. There are two reasons for this brevity. First, the state-run health system is an enormous and complicated organism. Attempting a full account would take up much more space than we have at our disposal, and moreover would provide far too much unnecessary detail for our present purposes.

In the second place, there is always the possibility of such a description going out of date. Ever since the 1980s, the state health system has been subjected to wave after wave of restructuring. User charges have been introduced and scrapped, hospitals have changed their names to Crown Health Enterprises and back again, the funding mechanism has moved from four Regional Health Authorities (RHAs) to one Health Funding Authority (HFA) to 21 **District Health Boards (DHBs)**... the list could go on. What follows relates to the system as it developed under the Labour Health Minister Annette King from 1999. Things may change again in the future. Therefore, you must imagine that every statement contained in this part has the cautionary words ‘at the time of writing’ attached.
This Act established the overall legislative framework within which the state health system was to operate. It introduced major structural reforms, like the creation of DHBs for the delivery of government funding. It also signalled a significant change in policy direction, from the spirit of commercialism and competitiveness that prevailed in the 1990s to a new concern for public service and cooperation.

This was the over-arching plan through which the new spirit of the Act was to be put into action. Future developments in the state health system were to be specific embodiments of the key principles guiding the Strategy (www.moh.govt.nz). These were rather high-mindedly abstract, but for the record they involved:

- Acknowledging the special relationship between Māori and the Crown under the Treaty of Waitangi
- Good health and wellbeing for all New Zealanders throughout their lives
- An improvement in health status of those currently disadvantaged
- Collaborative health promotion and disease and injury prevention by all sectors
- Timely and equitable access for all New Zealanders to a comprehensive range of health and disability services, regardless of ability to pay
- A high-performing system in which people have confidence.
- Active involvement of consumers and communities at all levels.

In down-to-earth terms, these lofty ideals were to be realised through the establishment of **Primary Health Organisations (PHOs)** that took the war against illness and injury out of the hospital and into the community. In recognition of the comparatively poor health status of many Māori people, a special branch of the overall Strategy, called **He Korowai Oranga**, was devoted to their needs.

**Minister of Health**
The Minister is the key government player in the Health game. During the period we are discussing it was the Hon Annette King. This is the Minister who has to compete with Cabinet colleagues to extract extra funding (known as **Vote Health**) from the Minister of Finance. More generally, the Minister is the person mainly responsible for setting the tone and direction of Government’s overall health policy.

**Ministry of Health**
This is the central nervous system of the octopus. In its own words (www.moh.govt.nz) the MOH:

- Provides policy advice on improving health outcomes, reducing inequalities, and increasing participation
• Acts as the Minister’s agent
• Monitors the performance of DHBs and other health sector Crown entities
• Implements, administers and enforces relevant legislation and regulations
• Provides health information and processes payments
• Facilitates collaboration and co-ordination within and across sectors
• Provides nationwide planning and maintenance of service frameworks
• Plans and funds public health, disability support services and other service areas that are retained centrally.

The MOH is a large bureaucratic empire, made up of a number of semi-autonomous Directorates, including ones for Mental Health Services, Disability Services, public health, and DHB Funding and Performance. It also gathers and disseminates useful statistics about the state of the nation’s health through its Information Service and Public Health Intelligence group.

National Health Committee
The NHC is an important advisory group to the MOH.

Commissions
A number of Commissions have been set up to act as watchdogs on the performance of state-funded medical practices. These are semi-independent state entities, funded by the government but licensed to probe and query aspects of the health system and possibly even challenge MOH philosophy. One instance is the Mental Health Commission, set up in the wake of the influential 1996 Mason Report on the abysmal state of the country’s mental health services. Its role is to monitor and report to Government on the performance of the Ministry of Health in the implementation of the government’s National Mental Health Strategy, to work with the mental health sector to promote better understanding by the public of mental illness, to eliminate discrimination, and to strengthen the mental health workforce.

There is also a Health and Disability Commissioner, who safeguards the rights of consumers, and to whom they can complain if they feel they have been badly treated.

Pharmac
This subsidises prescription drugs to the tune of over half a billion dollars a year.

District Health Boards
Although some MOH funding (e.g. for disability support services) flows directly out of the Ministry, most is channelled through the 21 DHBs. Your local DHB determines everything from the wages paid to home helps to the chances of your hospital getting a new CT Scanner. The Boards are, in principle, much more democratic than their predecessor the Health Funding Agency, as unlike it their members are nominated and voted for by the general public.
Ministry of Social Development

As we saw in a previous section, sickness is an economic as well as medical issue. When you are ill, you are often unable to support yourself and your dependents. If this is the case, another Government agency steps in. This is the Work and Income division (often but inaccurately called WINZ) of the Ministry of Social Development. One of its functions is to provide a minimal living wage, along with other forms of financial support (such as an accommodation allowance) for people who are knocked out of the labour force by poor health. If the illness is deemed only temporary, you get a Sickness Benefit (SB), while if you are judged incapacitated long-term, you go onto the slightly more generous Invalids Benefit (IB). Thus, while one governmental empire headed by the Minister of Health employs an army of workers and spends billions of dollars to look after our health, another one led by the Minister of Social Development spends billions more supporting us when ill.

In 2004 there were around 44,000 people on the SB and about 72,000 on the IB. (This and the following figures were taken from http://www.listener.co.nz/default,2703.sm.) Not only were these fairly high figures for a little country, but they were growing fast. The numbers on the SB were climbing at the rate of around 2,000 a year, those on the IB around 4,000. In the five years between 1999 and 2004, sickness beneficiaries had jumped by 34% and those on the Invalids Benefit by 41%. Furthermore, the numbers had already been tracking up steeply during the preceding decade: between 1990 and 1999, the SB numbers rose by 69% and the IB by 84%. Nobody knew exactly why the numbers on benefits were increasing at such a rate, but the main culprits were thought to be obesity and depression.

There are other overlaps between the MSW and the MOH as well as sickness and invalids benefits. For instance, in 2004 Social Development began buying hospital services for its beneficiaries from DHBs. They realised it would be much cheaper in the long run to pay for sick people to have operations quickly and get back to work rather than to linger indefinitely on the SB. More generally, the whole notion of ‘social development’ was regarded as integral to the promotion of good health. For instance, measures adopted by the MSD to tackle child poverty, such as those introduced by the 2004 ‘Working for Families’ budget, would eventually have positive spin-offs for the health of the nation’s children. Indeed, all investments by government in social development were also indirect investments in wellness. This is an important topic that will be developed further soon.

Accident Compensation Corporation

ACC stands a little to one side of the system we have just been sketching. Indeed, it is yet another state empire presided over by its own Minister. It is for victims of injury, not disease. It came into being in 1974, and provides a no-fault insurance scheme, paid for largely from levies on workers, employers and motorists. It was a visionary scheme at the outset, but frequently now gets bogged down in disputes and litigation with clients who feel ACC has treated them meanly or unjustly. For example, a 2003 survey of ACC clients (www.accforum.org.nz) revealed that the single biggest complaint about ACC was the lack of courtesy displayed by its staff. On the other hand, there is widespread dissatisfaction amongst those disabled by heredity or illness, rather than injury, who feel ACC clients are treated with considerably more generosity than is practised by MOH. One of the great anomalies in the country’s
health and disability provisions is that two people can experience exactly the same kind of impairment (e.g. being obliged to use a wheelchair) yet be treated unequally, depending on how it came about – by injury or by illness.

‘Whole of government’
Till now we have been focusing on the core of the state health and welfare system, concentrated in the MOH, Work and Income and ACC. However, just about every aspect of life, from the natural environment to macroeconomics, has a direct or indirect impact on our health. Consequently, every state agency must take health issues into account. It is a ‘whole-of-government’ affair.

In 2003, for instance, ACC launched an Injury Prevention Strategy, aimed at reducing the top six most prevalent causes of injury in this country, between them accounting for around 80% of serious injuries or deaths – road accidents, suicides, falls, workplace accidents, assaults and drownings. ACC coordinated the strategy, but also called in the Land Transport Safety Authority, the Ministry of Health, the Ministry of Youth Development, the Department of Labour, the Ministry of Justice, and the Ministry of Social Development. On another front, since there is a correlation between poor housing and poor health, the state agency Housing New Zealand has a responsibility not only for putting roofs over people’s heads, but ensuring that conditions underneath those roofs are healthy. In fact, just about everything government does has an impact on health somewhere down the line. For this reason, in 2004 the Health Impact Assessment (HIA) project was launched, to encourage all branches of central and local government to take the health implications of their policies and actions into account.

Having provided this quick and highly selective guided tour of some of the main features of the state health system as it developed between 2000 and 2005, we shall now go back in time to give a brief historical overview of some key policy changes in government’s role in the provision of health services. Our central theme will be the way the relationship between the state and civil society in health matters has changed radically from one epoch to another. The New Zealand government has always had its fingers in the medical pie, but how far they reached and what they got up to have varied considerably according to the brand of political philosophy that was dominant at the time.

Historical Overview

The Minimal State before the 1940s

The 1938 Social Security Act was a major turning point in New Zealand history. It was then that the foundations of the modern Welfare State (roughly 1938-1990) were laid. Before that, responsibility for the care and cure of injured or ill people was pretty much left to civil society, with only minimal state assistance. If you were sick, you depended in the first and last instance on your family, and whatever folk remedies they and their friends could come up with. If you needed a medical specialist, like a doctor, tohunga or midwife, you paid their fees yourself (unless they charitably waived them.) Similarly, you paid for your own treatment in a private hospital. Outside assistance was sometimes on hand from what today we could call
NGOs, such as Friendly Societies (mutual support groups of workers) and churches, who sometimes provided secular care for the body as well as religious care for the soul. On the whole, civil society was largely left to itself in health matters.

That said, the state was not entirely absent. In particular, it made its grudgingly benevolent presence felt in four areas. In the first place, from as early as the 1846 Lunatics Ordinance, state provision was made for those of unsound mind, embodied in rather grim ‘lunatic asylums’. Second, minimal pensions or compensation were provided from 1900 on, although only for a very few categories of the injured, ill or disabled (notably miners and the blind). Third, the 1885 Hospitals and Charitable Institutions Act established a hospital-based system of free health, financial support and relief in kind for the destitute. These provisions were very much in the charity mould, however, and many people did not like availing themselves of them for fear of being labelled as paupers.

Finally – and this is where we pick up on the struggle against infectious diseases described in the previous section – from quite early on the New Zealand government took on the responsibility for safeguarding population-based public health, given legislative expression amongst other things in the 1872 and 1900 Public Health Acts. Boards of diverse sorts were set up around the country to help combat the various epidemics of the time. Also, from the emergence of the Young Māori Party at the end of the 19th century, crusaders for better Māori health like Maui Pomare, Peter Buck, James Carroll and Apirana Ngata threw their weight into the public health campaign on behalf of the tangata whenua, who suffered from infectious and water-borne diseases at a much higher rate than others. On the whole, however, state health provisions before the 1940s were pretty minimal and grudging.

State and Medical Hegemony 1940s-1980s

There was a quantum leap in state-provided medical services after the 1938 Social Security Act. This was particularly manifest in the new role of public hospitals. Instead of these being a grudgingly provided charity for the more-or-less destitute, they became the cornerstone of the first Labour government’s vision of a universal health system open to all New Zealanders by right of citizenship. Everyone was entitled to the best medical care, regardless of their ability to pay, and there was no stigma attached to people who availed themselves of free hospital services. They rapidly became entrenched as an integral part of ‘the Kiwi way of life’.

The first Labour government also wanted visits to GPs and dentists to be free, but private practitioners put up such strong resistance to being incorporated into the state health system, the attempt had to be abandoned. The country thus acquired its characteristic mixed health economy, in which secondary and tertiary medical provisions (i.e. those based in public hospitals) were free, but fees had to be paid for primary services – that is, those provided by private practitioners out in the community. However, even there the state blunted the cutting edge of commercialism by providing generous subsidies for visits to the doctor, and it picked up the tab for prescribed pharmaceuticals. It also provided free dental treatment for all school children through a system of dental nurses, operating out of the ‘murder house’ that was an integral (if dreaded) feature of all New Zealand schools.
The main features of the medical landscape, however, were the public hospitals. Their presence, and also the way they functioned, had at least four advantages for patients. The biggest, of course, was that they were free. The second was that even comparatively small, rural communities had one. Third, they let patients stay around for a generous amount of time. People were not – as they are now – told to go home almost immediately after giving birth or having an operation. Finally, there was no shame attached to using them, as there had been under the old charity model.

However, the public hospitals of the Welfare State period had their drawbacks, both for patients and for governments. For the former, the hospital was like a big industrial factory, the only difference being it mass-processed human bodies rather than sheep carcasses. Patients were packed side-by-side with strangers in large, impersonal wards where they were patronised by remote doctors and bossy nurses. Little if any respect was shown for their individual dignity, their communal roots or for their cultural diversity. Hospitals were monolithic bureaucracies, where the interests and values of patients themselves were subordinated to medical and institutional imperatives.

The technical term for a situation where one group of people has gained total dominance over others is ‘hegemony’. The well-intentioned creation of the public hospital system had the unintended consequence of bringing a new form of medical hegemony into existence, in which ill or injured lay people were subjected en masse to the proclaimed expertise, but also to the whims, prejudices and blunders, of a newly dominant medical hierarchy. A handy term for this situation is ‘provider capture’. Those who provided services in public hospitals called the tune to which everyone else had to dance.

The public hospitals of the Welfare State period were thus paradoxical places. On the one hand, they represented a great advance over the minimalist state medical provisions that existed before the 1940s, and most New Zealanders felt their system of free state health care was much preferable to the user-pays system in countries like the United States. However, even though public hospitals cared well enough for patients’ basic physical needs, it was done at the expense of treating them as depersonalised ‘things’. The hospitals were heavy-handed, top-down, monocultural bureaucracies, presided over by autocratic medical personnel, and operating according to inflexible codes. Scant recognition was accorded to the individuality of patients, their communal bonds outside the hospital and their deep-rooted cultural values.

As is the way with hegemonic regimes, there was no way from within the system that its dominance could be challenged. If you wanted free medical treatment, you just gritted your teeth and put up with the cost in personal dignity that had to be paid. You also had to put up with any medical blunders that were inflicted on you, as few channels of protest and redress existed.

If public hospitals were a mixed blessing for patients, they were also an increasing liability for the state that set them up. As mentioned in the Economy section, the costs of scientific medicine increased in proportion to the wonders it could work. Ever more health conditions could be successfully treated, but to do so required increasingly expensive technology and medication. Furthermore, hospitals themselves
tended to be wasteful of resources, managed as they were by elected boards of local citizens (who knew little about medicine) and by senior doctors (who knew little about efficient management). To boot, there were arguably too many hospitals, duplicating services around many small districts which might have been more effectively managed through economies of scale – that is, centralising them in a smaller number of large, multi-purpose hospitals.

The upshot was that by the 1980s there was widespread disaffection from both the top and the bottom of the social pyramid with what had once been the jewel in the crown of New Zealand’s state health system – the public hospital. The various lines of discontent converged in the late 1980s, partly as a result of a major scandal at National Women’s Hospital in Auckland (more of that later), and partly because of the advent of New Right ideology. The double hegemony of the state and the medical profession, embodied in the public hospital, was attacked simultaneously on several fronts. Things were about to change – though not necessarily always for the better.

The Neo-liberal Market Approach 1990-1999

State funded medical services have experienced two major legislative earthquakes since the 1980s, as well as on-going swarms of after-shocks. The first big upheaval was announced in the 1993 Health and Disability Services Act, the second in the 2000 New Zealand Public Health and Disability Act. The first Act was introduced by the fourth National government at the very height of its ardour for New Right ideology. The second was passed by the Labour-led coalition in the first flush of its rediscovered enthusiasm for social democracy. The first moved the state health system markedly to the right, the second pushed it well back to the left. These Acts make a strange duo, as in most ways they were polar opposites, yet they shared a common spirit. We shall start by highlighting the differences, then later suggest what they had in common.

The neo-liberal reforms of the 1990s tackled the spiralling costs and the perceived inefficiencies of public hospitals, and indeed of the whole state medical system, by forcing them to swallow a large dose of free market medicine. Hospitals – henceforward to be known by the more business-like name of Crown Health Enterprises (CHEs), were to be run along competitive, business lines and managed by a new breed of hard-nosed corporate executives. Moreover, they had to compete for governmental contracts with myriads of other health providers from the commercial and voluntary sectors. Their numbers were also pruned to achieve the economies of scale mentioned earlier. Towns that had already lost public amenities like post offices now had to fight to retain their hospitals.

Patients – now known by the more market-oriented terms ‘clients’ or ‘consumers’ – had their subsidies slashed on goods such as prescription drugs, and for a while were expected to pay user charges for services in public hospitals (though this was so intensely unpopular it was soon dropped). Another manifestation of this ethos was the privatisation of workers’ compensation, which in the late 1990s was moved out from ACC and handed over to private insurance companies.

We will not go into these reforms in detail, as many have now been reversed. The general thrust, however, was that the state-funded health system should operate as
much like an open market place as possible. This was one manifestation of a more general drive by the New Right to get the state out of civil society. According to neo-liberal philosophy, the government should not be in the game of providing goods and services to its citizens. This was the role of the private sector, supplemented by the social capital that was supposed to abound in NGOs, local communities and families. In effect, the National government of the 1990s was trying to wind the historical clock back to the system of minimal state involvement in health matters that existed before 1938. This was partly motivated by the pressing need to restrain the skyrocketing medical costs that were making ever heavier demands on the state purse. However, it was underpinned by the sincere philosophical conviction that heavy state intervention threatened individual liberties. The reforms were ostensibly introduced to restore dignity and autonomy to health consumers.

There was more to the New Right reforms than just the neo-liberal suspicion of Big Brother State, though. It also contained a strong element of moral authoritarianism. While the neo-liberal right offered health consumers the carrot of personal autonomy, the authoritarian right applied the stick of coercion. If citizens were not enthusiastic about being sturdily self-sufficient, then ‘for their own good’ they were forced to be. They were placed under heavy state surveillance, the goods and services they formerly enjoyed by right were rationed, and they were pressured to accept responsibility for their own lives. It was a ‘tough love’ approach to health policy.

The first dose of tough love was administered straight after national came to power in 1990, when it was announced that the level of the Sickness Benefit was to be drastically cut. Pressure was then placed on sickness beneficiaries to get back to work, involving frequent medical scrutinies to check if they were ‘work ready’. This applied even to those suffering terminal cancer. In itself it is not unreasonable to expect people who have shaken off an illness to re-join the labour force. They should not be allowed to play ‘the sick role’ forever. It was the rather authoritarian and intrusive spirit in which the regime operated that upset beneficiaries. It seemed to work on the assumption that most sick people were malingering, and therefore required coercion to get them moving. Less concern appeared to be shown for people’s well-being than for removing them from the books. In requiring that civil society should take responsibility for its own health, the state itself was not always civil.

The punitive approach to welfare, however, was not particularly successful. As was noted earlier, numbers on the Sickness Benefit rose during the heyday of neo-liberalism by 69%, suggesting that the root of the problem lay not in people’s unwillingness to work but in their genuinely poor health. Bullying people to be healthy did not appear an effective way of combating illness.

The Primary Health revolution 2000-2008

When Labour’s Annette King took over the Health portfolio in 1999, she spearheaded something of a quiet revolution in this country’s state-funded medical care system. National had tried to hand it over to the market place, assuming the best health outcomes would be spontaneously generated by a Darwinian struggle between competing state, commercial and NGO providers. Labour firmly seized the helm and charted a totally different course – the 2000 Health Strategy (NZHS). The nation’s
health was once more to be the responsibility of Government – although in a very different way from the top-down, one-size-fits-all approach of the old Welfare State.

The NZHS involved a many-pronged campaign to reduce illness and injury, and to promote the newly fashionable ideal of ‘wellness’. Amongst other things, it put $200 million into a vaccination programme against the meningococcal B endemic, and it spent many millions more upgrading public hospitals at places like Kaitaia, Wairarapa, Thames and Dunstan. It demonstrated its commitment to a state-run injury insurance and prevention programme by moving workers’ compensation back from the private sector to ACC, while also restoring forms of compensation which had been axed during National’s austerity drive. We cannot go into all the details here, so will focus on Labour’s two major innovations – its primary health care policy, and its acknowledgment of the economic, social and cultural determinants of health.

In 2002, the first primary health organisation was launched. It was planned that by 2007, all New Zealanders would belong to a PHO, and thereby be entitled to considerably cheaper medical fees and prescription charges than previously. To this end, Government injected $1.7 billion into primary health care over six years, which would bring Vote Health up to around $10 billion, or 20% of all state spending.

As well as making health care more affordable, the government’s primary health strategy was intended to shift the centre of gravity away from public hospitals and into the community front line. Multi-disciplinary teams working for their local PHO try to nip serious illness in the bud by the early detection and treatment of symptoms, by providing comprehensive community care and by promoting good health practices. It was hoped that fewer people would end up in hospital, through the simple expedient of early intervention. There was to be a safety fence at the top of the cliff, rather than an ambulance at the bottom. PHOs were to be the jewel in the new state-funded health system, as public hospitals had been in the days of the old Welfare State.

There was another important point on which the post-1999 social democratic government differed from its predecessors as well. That was its sociological awareness of a theme that runs throughout the present text – namely, that people’s health status is to a large part determined by the wider context in which they are embedded. The rate at which they experience illness and injury, and the kinds of conditions from which they suffer, vary greatly according to where they are situated on the social map. This was first highlighted in the seminal National Health Committee 1998 publication The Social, Economic and Cultural Determinants of Health. The importance attached by the Labour government to the sociological orientation of this document can be seen in an extract from a speech made in 2004 by the Minister of Health (posted on the Annette King Mailing List 12 October 2004):

When the 1998 report came out, it was considered by the then government as what might be called ‘fringe thinking’. That’s certainly not the case now, of course. There is absolutely no doubt, as far as this Government is concerned, about the correlation between socio-economic factors and health. The 1998 report has become a seminal document for New Zealand public health, and its findings are now part of mainstream government policy and strategies, especially in the health sector. The New Zealand Health Strategy advocates that improving the health of New Zealanders must include a focus on factors like income, education, employment, housing and
access to healthcare services. It also emphasises the need to focus attention on those with the poorest health to reduce health disparities. In effect, the strategy acknowledges that although individuals should take responsibility for their own health, there are structural factors that may create barriers to achieving good health.

The obvious corollary of this statement is that good health is not just the business of doctors and nurses. As has already been emphasised in this module, inequalities in health are closely linked to other forms of inequality associated with factors like ethnicity, gender and socio-economic status. The post-1999 Labour-led government believed that these structural factors had to be addressed if New Zealand were to be a healthier nation. The major shift in state health policy after the 1999 elections graphically highlighted the difference between neo-liberal and social democratic philosophies. The former entrusted the nation’s health to the competitive market place. The latter acknowledged the underlying structural factors that led to poor health in the first place.

Return to Civil Society: consumers’ rights

In the above, the focus was on major differences between neo-liberal and social democratic approaches to the state health system from the 1990s. However, when this discussion began it was mentioned that although National and Labour were in many ways polar opposites, they nevertheless shared an underlying philosophy about the role of civil society in the prevention of illness and injury, and in the promotion of wellness. In their very different ways, they both rejected the double hegemony which dominated the medical system in the days of the full-blown Welfare State. In that period, the state was the major player in the health game, as signalled by the central role of the public hospital. Within that hospital, a rather autocratic class of doctors, backed up by a highly regimented hierarchy of nurses, ruled the roost. Wrapped in the mantle of scientific medicine, which few lay people dared challenge, white-coated professionals occupied the position in the health system that priests used to occupy in the Roman Catholic church. In all things, ‘doctor knows best’.

This began to change in the 1990s, however. On the one hand, Nanny State relaxed her smothering embrace on the health system. On the other, people started to challenge the absolute authority of the bio-medical establishment. A new, counter-hegemonic slogan was gaining currency: ‘The consumer knows best’. Patient power! The neo-liberal right and social democratic left went about promoting the consumer voice in quite different ways: during the 1990s, Government tended to lean back and fold its arms, while in the 2000s it lent forward to offer a helping hand. Even so, they agreed that patients’ rights, values and interests should be accorded much more respect than in the past.

The new health philosophy manifested itself through a shift in focus from the public hospital to the community. Since we are soon going to embark upon a whole section specifically dedicated to ‘Community’, a full discussion of this topic will be held over till then. Here, just one major chain of events that helped shift the centre of gravity from doctors to patients will be singled out, as a particularly striking illustration of a more general trend. This was what became known as ‘the unfortunate experiment’ at National Women’s Hospital in Auckland.
From the mid-sixties, Associate Professor Herbert Green conducted a long-running experiment with women who had a condition called carcinoma in situ. Contrary to the accepted wisdom of the time, Green believed this did not necessarily lead to cancer of the cervix, and he therefore left it untreated to check his own theory. Two leading activists in this country’s women’s health movement, Sandra Coney and Phillida Bunkle, publicised his experiment in a highly influential *Metro* article in 1987. Their denunciation of Green was partly motivated by the fact that a number of women involved in the programme did in fact develop full-blown cancer, but even more by the doctor’s unethical conduct in conducting an experiment on his patients without their knowledge and consent. Whether Green was right or wrong, it was generally regarded as morally reprehensible that he used women as guinea pigs.

At the formal enquiry that followed, headed by Judge Sylvia Cartwright, it emerged that the Green affair was just one particularly flagrant case of a much more widespread problem. It is the one to which we have already alluded – the autocratic attitude of the medical establishment, and the corollary failure to respect the dignity of health consumers. This was expressed most emphatically by the activists in groups such as Women’s Health Action, who had been complaining for many years about the various ways in which women were demeaned by a largely patriarchal medical establishment. It was not just a feminist issue, though. In the wake of the Cartwright enquiry, it was accepted at the highest governmental levels that medical practitioners were riding roughshod over the rights and values of patients, and that the latter had inadequate legislative protection against medical blunders.

One important legislative outcome of these snowballing grievances was the 1994 *Health and Disability Commissioner Act*. This not only set up formal channels through which patients could complain about the way they were treated, but also provided for a code of consumer rights, and a nationwide advocacy system to promote them. Perhaps the single most important stipulation of this code was that all health consumers should be treated with dignity. It was being stripped of such dignity that offended so many people under the old dispensation.

Patients’ rights were given further protection in the 1995 *Medical Practitioners Act*, which set up a regulatory and disciplinary framework intended to protect health consumers from the mistakes or ethical misconduct of doctors, and thereby restore the public’s confidence in the profession. Ten years later, the same concern about the safety of patients and their lack of faith in medical professionals still existed. They were addressed in the major new regulatory 2003 *Health Practitioners Competence Assurance Act*, and in the creation of a new medical disciplinary body under the amended Health and Disability Commissioner Act. In 2004, a booklet was widely circulated in all venues where the public came into contact with medical professionals, assuring the former that they could trust the latter. The implications were obvious. That the public required such reassurance, and that health practitioners needed such regulation, was symptomatic of widespread uneasiness about the perceived competence of health professionals and the quality of the system in which they practised.

We emphasise this point not in order to cast aspersions of our own on health professionals, but simply to highlight the changed perception of science-based medicine generally since the 1980s. Back in the days of the Welfare State, the doctor
enjoyed something of the same aura of infallibility as the Pope possessed within the Roman Catholic church. Since then, governments of both the right and the left, responding to strong pressure from groups such as Women’s Health Action, and from the consumer movement generally, have shifted the balance of power a little from health providers to health consumers. This, in turn, reflected a more general shift in the centre of gravity from the state to civil society.

The New Public Health: War on Non-communicable Diseases

In the next section on Community, we shall develop the topics touched on briefly above, such as the health consumer movement, patients’ rights and the postmodern shift from state to civil society. Now, however, we shall return the focus of the discussion to the state itself. In particular, we shall pick up the theme of public health that was introduced in the previous section on Population, and bring that story up to date. We concentrated before on how the state’s public health policies were directed towards the control of communicable diseases, such as smallpox, cholera and polio. Now we shall look at a more recent public health crusade that has been declared on non-communicable ones – that is, diseases that are not caused by infectious bugs, and therefore cannot be ‘caught’.

This campaign is sometimes called ‘the new public health’. What is ‘new’ about it is that its main target is not pathogenic micro-organisms but dysfunctional life styles, and its main weapon is not the hypodermic needle but public education. The emphasis has changed from fighting illness to promoting wellness.

The problem confronting the new public health is that today’s leading causes of morbidity and mortality (the technical words for illness and death) in New Zealand are not external agents of which we are the innocent victims, but conditions which, to some extent at least, people inflict upon themselves. Such conditions include type 2 diabetes, cardio-vascular complaints (e.g. strokes and heart attacks), and certain forms of cancer. We might also add road accidents to the list, as although they cause injuries rather than illness, they nevertheless stem in large part from life style factors such as the propensity of macho young males to drive recklessly. Instead of bugs making us ill, we are doing it to ourselves. Advanced countries are no longer plagued by diseases of poverty – they are, rather, victims of their own affluence.

The causes are quite simple – we are constantly informed of them by everything from lightweight articles in women’s magazines to heavyweight, demographic tables published by the MOH. First, we put the wrong things into our bodies. Some of us smoke too much, and many guzzle food and drink containing excessive animal fat, sugar, salt and commercial additives of one sort or another. As a result, our arteries get clogged up, we do not produce enough natural insulin, we trigger cancerous growths in our mouths, lungs, bowels, etc, we push our blood pressure up into the danger zone, and so on. Second, we do not offset these risks by doing enough exercise: Kiwis are turning into couch potatoes.

Public Enemy No. 1 in all this is obesity. It has become commonplace to talk about the current ‘obesity epidemic’, as once we discussed epidemics of infectious diseases.
Just as one representative sample of the widespread concern about New Zealand turning into a nation of ‘fatties’, here is a snippet from Annette King’s mailing list on 3 September 2004: ‘Recently released results from the 2002/03 New Zealand Health Survey indicate that 35 per cent of adult New Zealanders are overweight and a further 21 per cent of adult New Zealanders are obese. The data for children is equally alarming: 21 per cent of children from five to 14 years are overweight and a further 10 per cent obese.’

Māori and Pacific Islanders experience overweight and obesity at noticeably higher rates than other ethnic categories. They are also over-represented in the ranks of those suffering from ‘life style’ diseases and injuries, such as lung cancer, heart complaints, type 2 diabetes and road accidents. These two ethnic categories, in fact, are caught in a pincer movement between old-fashioned ‘diseases of poverty’ and newly acquired ‘diseases of affluence’.

Under the old public health regime, disease was combated through better sanitation, strict quarantining, vaccination and antibiotics. None of these work against drunk driving, smoking, over-indulgence in junk food and insufficient exercise. The new public health, therefore, has to work mainly through education and exhortation, backed up by punitive legislation where appropriate. On the punitive side, smoking has been banned in work places and social venues like bars and restaurants, while the police conduct regular blitzes on dangerous drivers and on people who fail to buckle themselves or their children up in safety belts. As for education and exhortation to lead healthier lives, this is conducted on many fronts from TV ads to marae-based programmes to encourage people to quit smoking.

The MOH is frequently in the forefront of the new public health strategies. For instance, in 2004 it launched the HEHA (Healthy Eating Healthy Action) campaign to promote better nutrition and more exercise, particularly amongst young people. Also in 2004, the Food Industry Accord between the MOH and the private sector was launched, with the hope of encouraging commercial food producers to do their bit in tackling the obesity problem. The contribution of junk food and drinks to this problem can be glimpsed in a message of 3 September 2004 on the Annette King mailing list: ‘Diet-related risk factors are now the major cause of death in New Zealand. The effects of diet on risk factors for chronic diseases are estimated to be responsible for about 30 percent of all deaths compared with 18 percent for tobacco and 10 percent for physical inactivity. Quite simply, that cannot continue, and the epidemic cannot be allowed to become worse.’

**The Structure-Agency Issue: Free Will vs Determinism**

When Christianity was the master narrative in the West, people were made to feel guilty about their spiritual sinning, were placed under constant surveillance by religious authorities, and were exhorted to seek heavenly salvation through penitence, prayers and faith. Today, there is a new secular morality abroad, whereby people are made to feel guilty about self-caused poor health, feel obliged to place their own life style under constant surveillance, and are exhorted to achieve the earthly salvation of ‘wellness’ through better diet and more exercise. Public health is well on its way to replacing religion as the guiding moral principle of our times.
The imperative to be healthy is hard to resist, since who can reasonably stand up for the right to smoke, to guzzle and to be a lazy slob? Nevertheless, mutinous mutterings can be heard in some quarters about being constantly chivvied, wheedled, begged or bullied into giving up bad habits. People resent having the beady eyes of Nanny State fixed on them reprovingly as they light up a cigarette, eat take-aways or watch videos instead of going to the gym.

There is more to this than just plain irritation. The new public health, with its insistence that most non-communicable disease could be eliminated if only people took a bit more responsibility for their own health, leads to the very heart of one of the thorniest of all sociological issues. Indeed, it plunges us into a moral dilemma that has vexed philosophers down the ages. In sociology, it is called ‘the structure-agency debate’. In philosophy, it is expressed as the opposition between ‘free will’ and ‘determinism’. It all boils down to one simple question: Why do I behave the way I do?

In very broad terms, there are three possible answers:

- **Biology.**
  I am programmed by my genes, and therefore have no control over the kind of person I am or how I act. This is called **biological determinism** and is a whole can of worms in its own right. We shall leave it to one side for our present purposes, and concentrate on the two remaining answers.

- **Society.**
  I am programmed by my social environment and by the history that created this environment. Since I am the product of the external structures and processes of society, I am not responsible for my own actions.

- **Choice.**
  I am a free agent and can therefore programme myself. I can choose between different courses of action, and I possess the personal willpower to act on my choices. My destiny is therefore in my own hands, not that of biology or history.

The debate over what drives human conduct is not just a matter of abstract philosophical theorising. Which side politicians take on the structure/agency, or free will/determinism, controversy has very real consequences for governmental policies, and therefore for New Zealanders lives at the grass or flax roots. It also has consequences for the ways in which individuals are morally judged by their fellows.

Take smoking, for instance. This is a major medical concern, as many people allege that smoking is a significant health hazard, particularly for Māori women, who are the heaviest smokers in the country, and whose rate of lung cancer is the highest in the world. If you believe in what sociologists call ‘agency’ and philosophers call ‘free will’, you will maintain that smoking is a personal life style choice. Nobody forces people to light up the next cigarette. True, quitting takes a certain amount of will power, but millions have done it, so it is not impossible. If you insist on smoking, in face of all the health warnings, you have nobody but yourself to blame if you end up
with emphysema or cancer of the mouth. Here’s how John Tamihere put it on his mailing list for 15 July 2003:

Some people may say that telling Māori to take responsibility for their own appalling smoking rates is blaming the victim, and I accept that smoking is a symptom of a wider malaise and deeper problems among our communities. But there are some simple facts that are not any less true because some people don’t want to hear them. If Māori want to stop dying prematurely and suffering from serious ill health, they should eat better, exercise more and stop smoking. Simple.

Those who prefer structural explanations to agency ones, however, put the blame on the historical background and social environment. If, for instance, Māori women smoke at a particularly high rate, it is in response to the stresses created by their situation at the bottom of the socio-economic hierarchy, which in turn stems from the massive disruption to traditional Māori society caused by colonisation. Indeed, poor Māori health generally is the fault of the double oppression of colonialism in the past and class inequalities in the present. It is the fault of the system, not Māori people’s own conduct. We must not blame the victim. This is how Tariana Turia put it on her mailing list for 2 October 2002:

In Aotearoa, our people were physically and culturally alienated by confiscations and crooked dealings in land, which left us dispossessed and dislocated. It is no coincidence that the rates of mental illness, crime, drug abuse, self-mutilation and suicide among our people have risen dramatically, as our ability to control our destiny and look after our own has come under increasing pressure. The loss of land and access to the resources and institutions of our culture is directly linked to the breakdown of our communities. The poverty amongst our people is a direct result of their losses.

Neither of the positions just outlined – pure structural determinism nor pure free agency – gives an adequate explanation of human conduct. In reality, everything that we are and do is the outcome of a complex relationship between external pressures and personal decisions, further complicated by the dictates of inherited genes. Thus, the structure/agency debate operates with a false dichotomy. Probably the best way of resolving the artificial opposition was formulated by Karl Marx when he wrote to the effect that humans can decide their own destinies, but under conditions not of their own making.

The fact remains that many people, including influential politicians, continue to speak and act as though there really is an either/or choice to be made between explanations of human behaviour based on determinism and those based on agency. This is where we get back to the central theme of this section – the role of the state in promoting the health of the nation.

At the risk of over-simplifying things a bit, we can hazard the generalisation that parties of the neo-liberal right, like National, operate from the assumption that individuals choose their own destinies, while parties of the social democratic left, like Labour, place much more emphasis on determining factors in the social environment, such as class, ethnic and gender inequalities.
We can see these differences in philosophical orientation at play by contrasting the New Right health reforms of 1993 with the social democratic reforms of 2000. The National government set up a system in which people were expected to take the responsibility for their own health. If they failed to accept the challenge, they were punished. Labour agreed that ultimately it was up to individuals to make sensible health choices, but also acknowledged there were many historical and structural factors at work which made it hard for some socially disadvantaged categories to break free from the illness trap. Marx’s ‘conditions not of their own making’ weighed particularly heavily on such categories. It was no use trying to bully them into better health. What the state needed to do was tackle the root causes of injury and disease in the underlying fabric of society, make medical services more affordable and congenial, and educate people about the desirability of quitting smoking, eating better and taking more exercise.

Both the right and the left require more involvement of civil society in health matters than was expected in the modernist Welfare State, but their expectations are couched in quite different forms. The right orders citizens to be free, the left encourages them. Either way, a new player has emerged in the health game over the last 20 years or so, that had been largely overlooked in the heyday of the modernist Welfare State. Its name is ‘community’. This is the subject of the section you are about to read.
SECTION SIX: COMMUNITY

Definitions

The term ‘community’ cropped up a number of times in our preceding discussion of the changed relationship between the state and civil society. In the present section, this theme will be picked up again and developed further by looking at three specific areas where the philosophy of community health care has been put into practice over the last 20 years or so. These are the deinstitutionalisation of psychiatric patients, the creation of Māori health collectives, and the home birth movement.

First, though, the matter of definitions must be tackled. The word ‘community’ is frequently used by policy makers, grassroots activists, the media and in everyday speech, but it is not always entirely clear what is meant. Community is one of those rather elusive concepts which is all things to all people, and is therefore employed in a variety of senses. This lack of precision is at the root of some of the major problems that bedevil those on the receiving end of community health services.

We shall suggest here two alternative ways of defining community, one as it is used loosely in common parlance, the other having more sociological precision. In the rest of the section, we shall alternate between these two ways of conceiving community. It should be clear from the context which meaning is uppermost.

Definition 1: The Voluntary Sector

First of all, let us clarify what appears to be meant by the word ‘community’ when it makes its frequent appearances in policy statements about the importance of community-based health services. It is obviously being contrasted with other forms of health provision, so the best place to start is those. What are the other options to which community care is said to be preferable? By figuring out what community health care is not, we can get a handle on what it is.

Not the state
First, the notion of community care is often used as the opposite of state provision. Instead of government telling people at the grass or flax roots what is good for them, they decide for themselves.

Not commercialism
In the second place, community care is represented as being performed out of altruistic motives, in contrast with the self-interested commercial approach of business entrepreneurs.

Not the hospital
Third, community care is regarded as a preferable alternative to treating patients in a hospital setting.

Not science-based medicine


Finally, (although this is not an essential defining characteristic) community-based therapy is supposed to be more holistic and natural than the biomedicine practised by orthodox doctors.

Here, then, are four things which community provision stands in opposition to: government bureaucracy, commercialism, hospitals and (sometimes) science-based medicine. The next question to ask is a more positive one. Where precisely can ‘the community’ that opposes these things be located in everyday parlance?

The answer lies back at the start of the previous section, where New Zealand’s mixed health economy was described in terms of three distinct tiers. These were the state, private enterprise and the voluntary or not-for-profit sectors. It is usually the third of these that people have in mind when they talk about community provisions. The voluntary sector contains four elements:

- Non-governmental organisations.
- The general public.
- Self-help groups.
- Family and friends.

When people talk about community health care in everyday speech, they usually have in mind one, some or all of those four ingredients. You will see the significance of this way of defining ‘community’ shortly, in the discussion of deinstitutionalisation.

**Definition 2: A Sense of Belonging**

There is a second and more sociological way of defining community, however. A community is a number of individuals or groups who feel that in some meaningful way they belong together. Literally or metaphorically they are ‘family’. They tend to create boundaries between themselves, the favoured in-group, and outsiders to their charmed circle. Their sense of common identity and their bonds of solidarity are embodied in a shared culture and history. There is one particular place where they all feel most at home, and they have a keenly developed sense of their collective honour. Finally, their communal voice is given expression by recognised leaders or activists, who keep the flame of group life burning and speak out for its interests and values.

Communities can be of any size, from two lovers to a worldwide social movement. In smaller communities, people tend to interact face-to-face and know one another personally, but there are larger ones, sometimes called ‘imagined communities’ whose members identify together emotionally, even though they may never have met.

**Romanticising Community**

A word of warning needs to be issued about the way that the term ‘community’ is used in some circles. It is often enveloped in a warm, fuzzy, romantic glow which gets in the way of clear-sighted analysis. Community is spoken about in almost...
reverential tones, as though it were the repository of everything most admirable and
desirable in the human condition – a refuge of personalised love, affirmation, support
and succour in a cold and impersonal world. For those who see it through rose-tinted
glasses, everything that is good about humanity is located in communal life, and
everything about that life is good. Furthermore, an extra, mystical dimension is
frequently added to the romantic aura, through the evocation of a quality vaguely
termed ‘spirituality’.

If you take those rose-tinted glasses off, however, things may look rather different.
For one thing, although it may well be true that close communal relationships bring
out the best in people, they can also bring out the worst. The family, which is the
prototype of all communities, can be a hotbed of aggression, resentment, jealousy,
possessiveness and unwholesome sexuality. Families can nourish their members, true,
but they can also mutilate them physically and emotionally in a myriad of unpleasant
ways, as can all other forms of communities.

For another thing, even when communities are supportive of their own members, they
can be destructively hostile to outsiders. In-groups seem to possess an innate sense of
dislike for all who live outside the communal palisades, expressing itself in
everything from mild contempt to murderous aggression. If there is such a thing as
‘evil’ in the world, it frequently has its origins in the communal sphere of the social
map, manifest both in the ways communities sometimes mistreat their own members,
and in their endemic xenophobia.

As sociologists, we must not let ourselves be swept away by the soft-hearted
sentimentality with which the word ‘community’ is often charged. We must also not
shrink from asking hard questions about what precisely is meant when the term
‘spiritual’ is employed. It is sometimes used as a shield to deflect precisely such
questions – which is all the more reason for asking them.

Having now equipped ourselves with two working definitions of the one word
community, one equating it with the not-for-profit sector of society, the other with a
sense of shared identity, we shall now see how they work out in practice. To start
with, the first definition will be used in connection with the philosophy of community
care for people experiencing serious mental disorders.

Deinstitutionalisation: Community Care and Mental Illness

Nowhere has the philosophy of community health care been put more vigorously into
practice, and nowhere have its pitfalls been more evident, than in the domain of
mental health services under the banner of ‘deinstitutionalisation’. This term refers to
the shift in psychiatric care from large, state institutions like Lake Alice, Kingsseat,
Seacliff and Porirua hospitals, presided over by a small elite of all-powerful
psychiatrists, to a miscellaneous range of provisions in the voluntary sector, packaged
together under the all-purpose label ‘community’.

From early colonial times right up to the 1980s, people experiencing severe mental
disorders (the Big Three being schizophrenia, acute depression and bipolar disorder)
were shut away in segregated institutions, known by a variety of pejorative
nicknames such as ‘the loony bin’ or ‘the funny farm’. Although by the 20th century
genuine attempts were being made to provide a pleasant, humane ambience, such as housing patients in modern villas, by all accounts psychiatric hospitals were rather grim and dehumanising places. Patients in hospitals such as Porirua were packed like sardines into over-crowded wards, and left to sit around unoccupied in dreary day rooms. They were regimented and bossed around by over-worked and under-trained nursing staff, with little if any respect for their personal needs, identities and dignity. Their personalities became institutionalised, totally dominated by the rules, routines and authoritarian hierarchy of the hospital system. They were often incarcerated against their wills, and the committal process robbed them of many basic civil rights.

Moreover, despite the almost god-like power wielded in those institutions by psychiatrists, the diagnostic categories through which they classified mental illnesses were imprecise, and they actually had little to offer in terms of effective medical treatment. In fact, some forms of so-called treatment that came on stream by the 1950s look to us today more like torture. Electro-convulsive therapy (ECT) was administered indiscriminately, without anaesthetic and often as a form of punishment. Even worse, chronic patients were subjected to an operation called lobotomy, whereby the nerves to and from the front lobe of the brain were severed, thereby robbing people of their identities. Vivid accounts of life on the inside during ‘the bad old days’ can be found in ex-patient Janet Frame’s books *Owls Do Cry*, *Faces in the Water* and *An Angel at My Table*.

This was the background against which the philosophy of deinstitutionalisation emerged. From the 1960s, both the psychiatric profession itself and the segregated institutions over which it presided came under increasing attack for the way they dehumanised their patients. It was slowly realised that locking people away in psychiatric hospitals did their mental and emotional conditions more harm than good. The drive to get patients out of closed medical institutions was greatly helped by the advent of new generations of drugs that suppressed the most extreme symptoms of psychosis, thereby allegedly enabling those experiencing it to live more or less ‘normal’ lives. They did not need to be physically confined in institutions, as their moods could be internally controlled through a diet of assorted pills. Long sojourns in hospital were no longer required, so long as people stayed on their medication.

Patients themselves often reported experiencing extremely unpleasant side effects from such drugs, and not infrequently stopped taking them once released from medical surveillance. Opponents of psychiatry maintained the new forms of pharmaceutical treatment simply replaced one form of control with another, condemning medication as a ‘chemical straitjacket’. Nevertheless, the new drugs appeared sufficiently effective to warrant entrusting them with the well-being of people experiencing mental illness. From the 1980s, psychiatric hospitals were reserved for short-term emergency care of those deemed to be a danger to themselves or others. Everyone else was handed a prescription for a cocktail of assorted chemicals and sent out to fend for themselves, with whatever support might be on offer from that vague abstraction The Community.

It must be emphasised there are large numbers of people involved. In 2004, there were around 37,000 people with mental illnesses on Sickness or Invalids Benefits (http://msw.govt.nz), and that was only the start. It is estimated that at any given time 20% of New Zealanders are suffering from some form of mental or emotional
disorder, of whom 3% (120,000 people) are suffering from acute conditions (http://www.newhealth.govt.nz/toolkits/mental%20health/background_2.htm). The precise statistics are not so important as the fact that many New Zealanders with debilitating psychiatric conditions are out there in the community. How do they fare?

**When Things Work Out Well**

Obviously we cannot make blanket generalisations about the individual living conditions of so many people. However, a considerable proportion are likely to be getting on with their lives in a reasonably independent and fulfilling way, perhaps with the help of mood-stabilising medication, perhaps without it. Some will have supportive and understanding families and friends. Good counselling services, sympathetic GPs and effective social workers may help them through the rough patches. There is also a jigsaw of community trusts and other not-for-profit agencies who provide a variety of support and advocacy services, from helping their clients find their way through the mental health maze, to getting them accommodation and work.

On the job front, there are two nationwide NGOs, Workbridge and Mainstream, dedicated to placing people with disabilities, including mental disorders, in paid employment. On the accommodation side, various types of housing are provided specifically for people with psychiatric conditions. If things work out well for you, there is thus a lot of assistance on offer, and much good will to tap into.

The new NGOs that provide community-based services operate from a very different philosophy from the authoritarian ethos of the old, long-stay hospitals. It can be glimpsed, as a representative example, in the following extract from the web page of one such trust called Wellink where the agency’s guiding principles are laid out:

- Engaging the skills and resources of local communities to assist with peoples’ mental health recovery
- Acknowledging that people generally have an inherent ability to self heal and a deep inner knowledge about how to go about this. People should be supported to work with these strengths – not have health solutions imposed on them
- Seeking to understand humanity rather than diagnose mental illnesses in supporting people in their mental health recovery
- valuing authentic human qualities such as common sense, respect, compassion, self-awareness and community building (rather than clinical qualifications) as the basic building blocks of a good mental health service.

(http://www.newhealth.govt.nz/toolkits/mental%20health/background_2.htm),

**The user self-help movement**

The above quote clearly displays a more respectful attitude towards people experiencing mental disorders than the one that prevailed in the old system. A major contributing factor to this changed tone was probably the advent of the mental health
services user movement. This began in New Zealand around the mid-1980s with the creation in Auckland of a self-help group called Psychiatric Survivors. Since then, an increasing number of mental health service users or ex-users have spoken up on their own behalf. They have narrated their own stories in books like *A Gift of Stories* and *Narratives of recovery from disabling mental health problems*. Former patients have created consumer-run advocacy and support networks around the country, and some of them have become service providers in their own right. Several have even been appointed to key positions within the mental health establishment, including the founder of Psychiatric Survivors Mary O’Hagan, who was diagnosed at 18 with an allegedly incurable depressive psychosis, but in 2000 was appointed a Mental Health Commissioner.

What Mary O’Hagan and others in the mental health user movement have been crusading for in recent years is the ultimate in community care. They have gone from demanding that the mainstream community should provide adequate services for its ill members, to mental health users empowering themselves. The ‘survivors of psychiatry’ vary in their tactics. Some advocate total separatism, refusing to have any truck with the orthodox mental health establishment. Others believe it is possible to forge symbiotic working partnerships with mainstream services, so long as their own identity, experience, outlook and competence are respected. Whatever the tactics, the long-term goal is that those with experience of mental illness should be actively engaged in forging their own destinies, not passive recipients of medical regimes and state provisions imposed on them from on high.

**When Things Do Not Work Out**

In the above, we have been talking about the best case scenario. When things work out well, it is possible for people with even severe mental or emotional disorders to live thoroughly fulfilling lives. At one extreme, medication allows them to ignore their condition most of the time, while at the other extreme they actively celebrate their self-proclaimed ‘madness’ alongside fellow members of the user movement.

The story does not always have a happy ending, however. Back in 1996, an enquiry into how the new philosophy of community care was working out in practice, usually referred to as *The Mason Report*, produced what amounted to a sweeping indictment of New Zealand’s mental health services. Things may be a little better today, but even now many people are badly let down by community care – or, it might be more accurate to say, lack of care.

The country’s mental health services are afflicted by what might be termed ‘social entropy’. Entropy is a scientific term referring to the way in which a closed system degenerates into disorder, randomness or chaos as particles go flying off in different directions. The same anarchic tendency prevails in human as in natural systems. The disordered particles in question now are isolated human beings – in our case, those with severe mental disorders. No longer able to avail themselves of the long-stay services provided by the old psychiatric hospitals (no matter how inadequate those services may have been), they are often left to drift on the random currents of mainstream society. If support is not at hand, they tend to end up at the bottom or on the margins of that stream, the most excluded of the excluded, the underside of the under-class.
It is often very difficult for people with severe mental or emotional problems to gain regular paid employment, so they may be obliged to live in perpetuity on a minimal state benefit. Accommodation is another chronic problem: they sometimes subsist in cheap, seedy boarding houses, or become street vagrants. Furthermore, their mental condition combined with their alienated social situation makes it difficult for them to forge emotionally fulfilling and supportive relationships, so their poverty is compounded by loneliness. Their social alienation also causes them to get on the wrong side of the law at a disproportionately high rate: when they should be receiving proper medical care, they may end up in jail.

The reason why these unfortunate human particles fly off on their random trajectories varies from individual to individual, situation to situation, and town to town. It is usually possible, however, to trace back lines of causality and identify weak points in the system.

The problems often begin in the very place we would expect them to be fixed – the hospital. You can only get psychiatric attention if your condition is manifestly so severe it cannot be ignored. Even then, you may be turned away if an emergency occurs, and someone whose situation is deemed more urgent than yours is brought in. Psychiatric units and hospitals seem to stagger perpetually from one crisis to another, with never enough personnel to cope, nor beds to accommodate all those in need. Consequently, there are many people with severe mental illnesses not receiving the on-going hospital attention they require. Often you can only get help when your situation is so bad, it may be too late. In the old ‘lunatic asylums’, people may have been robbed of their dignity, but were at least looked after. Today, many people regret the absence of secure asylums – where the word ‘asylum’ is meant in its original sense of a safe refuge from a hostile world.

If you have no luck getting help from a hospital, where else are you likely to turn? There is, of course, your GP, who may be able to prescribe you some anti-depressants, but he or she does not have the psychiatric expertise to get to grips with your underlying condition, and certainly can do little about getting you a home or job, or helping you overcome your profound sense of social alienation. On another front, you may be fortunate in having a supportive family or friends, but very often mental illness goes hand-in-hand with the breakdown of formerly supportive relationships, with the result that those with psychiatric disorders may become alienated from the very people who are best placed to help them.

There may be a good community trust in your vicinity to partially take the place of family and friends, but many towns do not have mental health NGOs on tap. Furthermore, they vary considerably in quality from place to place, and are under such pressure they may not have room for you on their books. Another option is the self-help user network mentioned earlier. You may not find it congenial, however, to spend all your time mixing with other ‘mad’ people. Besides, just because they have experienced mental illness does not automatically qualify them to give you the type of assistance you need.

We could keep drawing up a checklist of the kinds of people who might be able to help – counsellors, social workers, the staff of your halfway house, even at a pinch.
the police. All such people, along with those mentioned in the previous paragraphs, can and do provide stalwart support services on occasions. Our point here, though, is that they may also let you down. Collectively, they constitute the social system that guards against human entropy. However, several parts of the system may fail simultaneously. When this happens, the lives of people with mental disorders risk sliding into chaos. At best this generates chronic unhappiness, at worst it ends in tragedy. We can all remember shocking news stories over the last few years of brutal and sometimes macabre homicides committed by people under the influence of paranoid delusions, their victims typically being family or friends. What is less well publicised is the much greater number of people, often young ones, who have killed themselves while in the thrall of mental illness. On almost all occasions, both forms of violence can be traced back to failures in some or all parts of the haphazard affair called ‘community care’.

It is the very haphazardness which is the main problem. People in different parts of the system do not liaise with one another. Nobody takes overall responsibility for integrating the care package. Each person who interacts with the consumer sees one part of the jigsaw, but the big picture is often lacking. We referred earlier to community care as a ‘system’, but the word is probably too generous. The main reason why so many people with serious mental disorders fell through the cracks during the deinstitutionalisation process was that there actually was no system in place to integrate the human particles that it released into the community.

Stigma

There is one other item that needs to be added to our checklist of reasons why community care has let so many people down. This is the stigma (i.e. the sense of disgrace) attached to mental illness by many members of the general public. People often feel uncomfortable around those with mental disorders, whose speech, appearance and behaviour can be off-putting. Worse, the sometimes grisly homicides committed by a very small number of seriously disturbed people inevitably grab the headlines and haunt the popular imagination. Such real life tragedies reinforce the stereotype of the psychopathic killer projected by so many cinema and TV thrillers. ‘Mad’ and ‘bad’ blur together in the public mind. An almost superstitious dread is associated with madness, particularly schizophrenia. People known to have mental illnesses therefore tend to be shunned, as manifest by the widespread ‘Nimby’ (not in my back yard) syndrome: New Zealanders are okay about community care, so long as it does not happen in their own neighbourhood.

To make matters worse, those experiencing mental illness frequently internalise the stigma. Seeing themselves through the eyes of others, they sometimes feel humiliated by their own condition. Shame dogs the footsteps of the mentally ill.

There have been strenuous, state-backed campaigns to reduce such discrimination. It was officially outlawed by the 1993 Human Rights Act, while the long running Like Minds, Like Mine TV ads attempted to soften public perceptions of mental illness. Today, on the surface at least, it is not considered so disgraceful for you or a member of your family to have a mental illness as it was in the bad old days of the ‘loony bin’. Even so, many users of mental health services feel that the greatest disability they
face is not so much their actual condition as the prejudice they so often encounter in everyday life.

The upshot of all this is that although the ideology of community care is well intentioned, there is an old adage about the road to hell being paved with good intentions. Because the deinstitutionalisation process was not adequately planned, resourced or integrated, many former long-stay patients ended up not so much in the community as in the social gutter.

**Māori health: Tino Rangatiratanga and Whanaungatanga**

Since the 1980s, the second article of the Treaty of Waitangi guaranteeing Māori tribes tino rangatiratanga, of which one translation is self-governance, has come back on the national agenda, after being largely absent since the 1860s. With it has come a renaissance of Māori community identity, which had experienced something of an eclipse during the urban migration of the post-war decades. Over the last 20 years or so, iwi, hapu and whanau have had at least a limited range of their traditional functions restored to them. In terms of the structure-agency debate discussed in the previous section, Māori communities have increasingly been recognised as agents of their own destinies, rather than colonised subjects of imported economic, political, legal and cultural structures.

This reassertion of Māoritanga (Māoriness) comes in two distinct guises. On the one hand, in some places it is linked with the revitalisation of traditional tribal identities, as maintained through whakapapa (genealogy) and turangawaewae (a place to stand: tribal heartland). For what might be termed ‘iwi fundamentalists’, personal identity is bounded on all sides by tribal identity, embodied in traditional culture and customs passed down from the tipuna (ancestors). For them, ‘being Māori’ means first and foremost being Ngati Porou, Tainui, Ngati Whatua, Ngai Tahu or whatever. They practice what might be termed ‘the politics of identity’. That is, all thought, emotion and action is geared towards the assertion of tribal mana in face both of white colonialism and the mana of rival Māori kin groups.

Most Māori people today, however, do not still live in the ancestral heartland of the tribe, but in the urban environments of places like West Auckland, Manukau City, Porirua and Wanuiomata. Their original tribal identity may mean little or nothing to them, and they lack fluency in ancestral customs and culture. Their lives, like those of other New Zealanders, are dominated by socio-economic imperatives, not the politics of traditional identity. Nevertheless, they ‘feel Māori’, and are probably most at ease when mixing with fellow city Māori. They retain a sense of communal identity, but it is embodied in new urban organisations, such as the Hoani Waititi and Te Puea marae, the Whanau o Waipareira Trust and the Manukau Urban Māori Authority.

Whether iwi or city based, community is a core feature of Māori social life. It is often embodied in the terms ‘whanau’ (family) or ‘whanaungatanga’ (family spirit), which are frequently used in place of the English word ‘community’. They can refer either to the literal family of people related by blood, marriage or adoption, or else to metaphorical families, such as Te Whanau o Waipareira, where people may not be related by kinship, but feel that they belong together. During the Māori renaissance of the last few decades, the centrality of whanaungatanga to Māori identity has been
vigorously reasserted, accompanied by the Treaty-based demand that Māori communities should have a large degree of autonomy to run their own affairs, free from state interference.

**Self-governance and Health**

All this is highly relevant to our central subject – health. From the start of life, where the Sudden Infant Death Syndrome (SIDS) is far higher amongst Māori than amongst other New Zealanders, to the end of life, where Māori on average die nine years younger than the national average, the health of the tangata whenua is significantly poorer than other ethnic groups. (A comprehensive overview of this subject can be found in the first two chapters of Mason Durie’s book *Mauri Ora: Dimensions of Māori Health.*) Cutting their illness and injury rates and improving their level of all-round wellness is therefore high on the agenda for all Māori communities, be they traditional or modern in outlook, rural or urban, tribal or non-tribal. Taking control of their own health is an integral component of the overall drive for communal self-determination.

During the first three decades or so of the great post-war urban migration, Māori depended largely on state-run health services dominated almost entirely by non-Māori, as epitomised above all by the public hospital. In medical matters as in everything else, Māori were supposed to assimilate themselves to Pakeha ways of doing things. Hospitals were massively monocultural affairs, where Pakeha doctors and nurses had little if any knowledge of, and respect for, distinctively Māori beliefs, values and feelings. The hospital is an alien place for all patients, but it was doubly alien to many tangata whenua, abruptly torn out of their familiar communal settings and exposed to the impersonal gaze of white strangers.

A campaign was mounted in the early 1990s to challenge this monoculturalism from within the system. In 1992, a large module on so-called Cultural Safety was introduced into the curriculum for student nurses and midwives. Its intention was to make them more sensitive to the outlooks of those from ethnic groups other than their own. In practice, the courses tended to be largely devoted to Treaty issues and traditional Māori customs, which generated considerable public controversy. Allegations were made that education in sound clinical practices were being sacrificed to a kind of brainwashing process, whereby non-Māori students were force-fed ‘politically correct’ Māori ideology. Whatever the truth of these criticisms, the Cultural Safety component of nursing education had the merit of alerting Pakeha nurses and midwives to the crucial sociological fact that different communities have their own distinctive patterns of thought and feeling. They should not be squeezed into the one-size-fits-all mould that had previously prevailed in public hospitals.

An even bigger challenge was mounted to the hegemony of the state and the white medical establishment from outside the system. As the centre of gravity shifted from the public sector to civil society in the 1990s, the responsibility for Māori health was increasingly contracted out to a growing number of all-Māori provider groups. Some were dedicated solely to health services, often having the word ‘ora’ (health) in their titles, while others included a health portfolio amongst a variety of other self-help programmes, such as employment, education, housing, cultural development and business enterprise. They were brought together under one umbrella and given fresh
impetus by the over-arching Māori health strategy He Korowai Oranga (cloak of health) that was launched in 2002.

Whatever the precise form Māori health initiatives took, they all had a similar philosophy. They opposed the tendency of Western biomedicine to focus on just one, pathological part of the body. Instead they stressed the need for a holistic approach, which related health to the wider communal and cultural context. This holism was expressed in two frequently re-cycled metaphors. One likened the determinants of health to the four walls of a whare (house) – physical, mental, familial and spiritual. An even more ambitious image compared the factors involved in wellness to the eight tentacles of a wheke (octopus). These, however, were simply poetic renderings of principles incorporated by government in the 2000 New Zealand Health Strategy. Three such principles were the philosophy of integrated primary health care, the new public health emphasis on the need for healthy life styles, and the recognition of the social, economic and cultural determinants of health. There was thus a confluence of Māori and governmental outlooks at the start of the 21st century. The one used metaphors, the other used public policy terminology, but they were basically speaking the same language. Health cannot be divorced from its communal setting. Each community should be empowered to go about generating wellness in the way it deems most appropriate to itself.

One of the strongest advocates for Māori self-determination in health matters has been Tariana Turia, the co-leader of the Maori Party. To give you the flavour of her vision for tino rangatiratanga in action, we shall now break off our own narrative and hand over the speaking voice to her. What follows are a series of extracts from speeches about Māori health made by Tariana Turia in 2002, when she was a government minister at the time He Korowai Oranga was launched, and were subsequently posted on her electronic mailing list. They provide a classic illustration of the rhetoric through which tino rangatiratanga and whanaungatanga in health matters is promoted. Where Turia uses the term ‘whanau’ in the following, it is probably legitimate to substitute the English word ‘community’.

Rangatiratanga does not mean separatism. It does, however, require recognition by central government of the distinct communities of tangata whenua, and acceptance that tangata whenua know better than central government what’s best for themselves. It requires engagement with their leadership, and support for their efforts to set and reach their own goals. (19 July 2002).

At the end of the day, stronger whanau enable tangata whenua to maintain our identity, and to protect our future by taking charge of our own destiny. He Korowai Oranga supports the rangatiratanga of tangata whenua, meaning that whanau will define what outcomes they want from health spending, what are the spending priorities, and how services should be organised to achieve their goals. (30 September 2002).

He Korowai Oranga has released enormous energy in the health sector by harnessing the strength of whanau and encouraging whanau to pursue their own priorities. This is a fundamental paradigm shift for the health system. Instead of treating individuals simply as patients, the system recognises them as tangata whenua, whose mana, identity and strength comes from their membership of whanau. This has opened the way for a second paradigm shift – from a deficit model to a development model. In other words, a focus on whanau potential, not individual problems. We identify what the whanau does well and support that, instead of treating the symptoms of a
breakdown. There are real health benefits for individuals when whanau have improved housing, employment, and better education. He Korowai Oranga extends that to include anything that makes the whanau stronger – like learning te reo, knowing tribal history and whakapapa, or joining in marae-based activities. These aspects of our collective culture bind our whanau together, and in turn, our whanau maintain our tikanga tuku iho as a living culture.

But there are inherent dangers. Evaluating someone’s work against objective, measurable standards has not always been part of our tikanga. In a tangata whenua paradigm, what counts are the strength of your relationships with the whanau, and your contribution to whanau goals. Is the whanau as a unit stronger for your work? Do you uphold the tikanga of the whanau in your work? There is certainly no simple formula to enable government agencies to measure your contribution. It goes back to accountabilities. You must remain accountable to the whanau; and the whanau, not the government or the PHO, must hold you to account for delivering the results THEY want. The whanau must be involved in setting the standards they expect, and monitoring your performance. (2 October 2002).

Whanau is the foundation of tangata whenua social, cultural and political organisation. It is the source of identity, security, support and strength. He Korowai Oranga places whanau at the centre of public policy. The ultimate aim of He Korowai Oranga is whanau ora – our families supported to achieve their maximum health and well-being. Health is the focus of this strategy – but it is more than a health strategy. It embraces all the factors that can affect health. A whanau ora is not just a group of healthy individuals in a nice house with a vegie garden. They also have healthy relationships based on common values, and they have organisation and leadership. This enables them to unite as a whanau, and to work with others, to control their lives and destiny. (13 November 2002).

The above quotes give the flavour of the rhetoric surrounding the campaign for Māori-led community health services. The constant theme is that all will be well in the Māori world if only full responsibility is handed over to whanau. This, however, begs the question of whether whanau are equal to the heavy responsibilities they are expected to carry. As sociologists, we must be on our guard against letting rhetoric have the final word. The ideology must be checked against empirical reality, and we must ask what underlying motives drive the ideology in the first place.

Above all, as mentioned near the start of this section, sociologists should not allow themselves to be seduced by the warm, fuzzy, romantic aura that often surrounds discourse about community. Communities are not the repositories of all virtue. They may act in good faith, but they may also act in bad faith. They may arrive at wise decisions, but they are equally capable of folly. Their proclaimed strengths may mask incompetence. They demand respect, but do not necessarily merit it. They celebrate solidarity, yet may be riddled with schisms and feuds. Māori whanau are no exception. We shall leave the subject there for the moment, but in the concluding paragraphs of this section some more warnings will be issued against uncritically accepting communitarian philosophy, including tino rangatiratanga, at its own face value.

The Women’s Health Movement and Home Birth
There is a snappy saying which is recycled in just about everything written on health and society: ‘Women are sicker, but men die quicker’. The empirical fact underlying this adage is that the overall health status of males is worse than women’s, as on average they die around seven years younger, yet in day-to-day life women present themselves more frequently to medical practitioners. (Amongst many other places, the statistics can be found in the 2004 publication Portrait of Health.)

Nobody is quite sure why women appear to have worse health than men. In some cases it is obviously because they experience certain conditions at an objectively verifiable higher rate. For instance, it is an empirical fact that after menopause females suffer far more than males from a weakening of the bones called osteoporosis, often caused by a reduction in the supply of the female hormone estrogen. On another front, women are significantly more likely than men to be on medication for depression than are men, to the point where tranquillisers and anti-depressants have been nicknamed ‘mother’s little helpers’. (Incidentally, it was a New Zealand psychiatrist who invented the term ‘suburban neurosis’ for the endemic mood problems afflicting so many women shut away from mainstream social life in domestic prisons.) On yet another front, it is only women who gestate and give birth to babies. Even normal pregnancies can take a high toll on the maternal body, and require women to undergo regular clinical surveillance. When complications set in, emergency medical intervention is required. In such cases, there are clear objective reasons why factors associated with female biology or social circumstances should bring them into more frequent contact than males with health providers.

On the other hand, it may just be that women are more health-conscious than men, may monitor their own moods and bodies more closely, and may be more willing to consult medical practitioners. Whatever the reasons, issues surrounding health are of major concern to women. It was hardly surprising, then, that when the so-called ‘second wave of feminism’ hit New Zealand in the late 1960s, medical matters were high on the agenda.

There had been a strong women’s health movement back in the days of the first wave of feminism in the late 19th and early 20th centuries. This was revitalised by the new feminists, operating mainly through grassroots women’s health collectives, but spearheaded by nationally recognised leaders like Sandra Coney and Phillida Bunkle. They operated on a number of fronts, including blacklisting obnoxious male doctors, promoting alternative therapies to orthodox bio-science, agitating for the right of women to control their own reproductive functions, and for several years operating the Save Our Sisters (SOS) underground network to assist New Zealanders to get abortions in Australia. Here, just one representative campaign will be explored – the home birth movement that gathered momentum in New Zealand from the 1980s.

**Home Birth**

The home birth movement was driven by the disaffection felt by many women towards what they regarded as the over-medicalisation of pregnancy and child birth. In traditional societies, these had been regarded as natural processes, occurring within the ongoing round of community life. If advice was needed during pregnancy, or help required during labour, it was provided by female family members and friends, backed up at crucial moments by a midwife. It was very much an all-woman affair, in
which female solidarity and empathy were generated by what, after all, was a uniquely female experience. Men, who ruled the roost in most other matters, were firmly excluded from the sisterhood of parturition.

During the long hegemony of the modernist hospital, the mystery, pain and triumph of childbirth were torn out of the natural cycle, out of the communal setting and out of the experience-based expertise of women. These were replaced by intrusive medical technology, standardised clinical procedures, the bureaucratic routines of the hospital ward, and the authority of male doctors. This medicalisation of reproduction may arguably have saved many lives, as it was tragically common in traditional societies for women and/or their babies to die in childbirth, but many mothers felt such progress had been bought at the expense of their personal dignity and the communal bonds that united them with other women during the most essentially female of all experiences.

Today, the wheel has turned again. Home birth is still a minority choice, but it is one that women are empowered to make for themselves. There is no longer the de facto compulsory hospitalisation of labour that prevailed up till the 1990s. The home birth movement, along with the other campaigns conducted by the New Zealand women’s health movement, is a classic instance of the philosophy of community care. It has most of the features that were described near the start of the section. It can be defined negatively in terms of its opposition to the dual hegemony over women’s bodies of the state and the (mainly male) medical establishment. It prefers treatment in the home to hospital-based services. It looks for congenial alternatives to hard-edged clinical technology. It treats pregnant and labouring women as whole human beings, not just wombs and vaginas. The birth process is presided over by those regarded as sympathetic members of the in-group community, rather than impersonal outsiders. Finally, for some women at least, natural home birth is a symbolic affirmation of self-identification and solidarity with the sisterhood of women, defiantly outside the orbit of patriarchal authority. It is an affirmation of the Female principle against the dominance of Man.

Re-enter the midwife

Now we must introduce a figure who has only been hovering in the margins of the story. For most of the 20th century she was relegated to a subsidiary role in the birthing process, even though before that she had been the major actor. This figure is the midwife.

In all traditional societies, including colonial New Zealand, it was to midwives that women turned when in labour. They were the experts in the field, even if their expertise stemmed mainly from experience rather than formal medical education (which, in any case, was not open to women until a century or so ago). However, as science-based medicine became an increasingly respected, powerful and lucrative profession, doctors (of whom the vast majority used to be men) gradually monopolised all its branches, including gynaecology and obstetrics. They still needed female attendants to perform all the menial tasks their professional dignity prevented them undertaking themselves, but women were delegated only a secondary role in the birthing process. The formerly autonomous occupation of midwife became subordinated in the 20th century to the authority of the medically qualified doctor. In fact, they virtually lost the name ‘midwives’, becoming instead just plain nurses, with
the terms ‘maternity’ or ‘obstetric’ tagged on. That is, they lost their distinct communal identity and collective status, reduced instead to just more anonymous workers within the vast medical bureaucracy. (The full story is told in Chapter 2 of Nursing in New Zealand, edited by Elaine Papps.)

Admittedly, midwifery nurses may have benefited considerably from the formal state education they received, and it may not have been at all a bad thing that their activities were regulated and monitored. There is no need to romanticise ‘the good old days’ of the traditional Wise Woman. Midwives in former times were, like everyone else, a mixed lot, some skilful, others incompetent. The systematic training and surveillance that accompanied the medicalisation of obstetrics was probably a boon to birthing women generally. However, even if it could be argued there was a general advance in clinical competence, the fact remains that an entire occupational community had been disempowered.

This is where we re-join the home birth movement. One consequence of former midwives being assimilated into the hospital system was that women who wanted to have their babies at home found it difficult to get anyone with birthing expertise to attend them there. Conversely, since most women had been indoctrinated with the notion that it was virtually compulsory to go to hospital when labour began, there were few potential clients for domiciliary midwives.

From the 1980s, this self-perpetuating cycle, which confined both midwives and mothers-to-be in hospital wards, was broken. A mutually empowering symbiosis developed between women pressing for a return to home-based labour, and midwives struggling to reassert their distinct professional status. The two mutually dependent sides came together, as manifest amongst other things in the Save Our Midwives campaign run by women wanting home births.

A professional community that had been eclipsed for the best part of a century re-emerged into the light. In 1989, the New Zealand College of Midwives was formed, and in 1990 an Amendment to the 1997 Nurses Act gave midwives the right to work as medical practitioners in their own right, vested with some of the powers of a doctor.

Midwives reclaimed their traditional role through struggles conducted on two fronts simultaneously. On the one hand, they extracted themselves from under the dominance of doctors, while on the other they proclaimed a distinct identity from nurses. Today, if you qualify as a midwife, you cannot practise as a nurse, and vice versa.

There is a sequel to this story with a revealing sociological message. When midwives were professionally empowered in the 1990s, doctors began leaving the field in droves. Ostensibly this was to express their alarm about the potential dangers of home birthing, and the inability of midwives to cope effectively with medical complications. A number of highly publicised cases of precisely such problems gave some credence to these medical concerns. However, there was a more purely sociological principle at play as well.
One major defining characteristic of any community is its jealously guarded sense of what might variously be termed status, esteem, honour, dignity, standing, pride, reputation, distinction or mana. Communities are status groups. Having midwifery nurses acting as their handmaidens bolstered doctors’ sense of collective self-importance. Once midwives got out from under their control and set up as an occupational community with standing in its own right, however, attending to expecting mothers lost much of its professional mana for doctors. The moral of this tale for sociologists is that beneath surface claims of altruism, community life seethes with the twin emotions of pride and resentment. During the three-way battle between midwives, nurses and doctors, all sides proclaimed their only concern was for the well-being of expecting mothers. There is no reason to doubt such concern, but equally undoubtable has been the role of status striving on the part of all three professional communities. Public declarations of altruism are frequently laced with a large dose of communal self-interest. As sociologists, we will fail to penetrate to the wellsprings of human action if we ignore the major part played in it by communal self-aggrandisement.

The Functions and Dysfunctions of Community Health Care

Having sketched three areas in which the philosophy of community health care has been put into practice in recent years, let us now stand back and risk some generalisations. Handing a large part of the responsibility for medical provision over from the state, the hospital and the orthodox medical practitioner to this open-ended thing we call ‘community’ has been a mixed blessing. Most people today at least pay lip service to the importance of the community in preventing illness and injury and in promoting wellness, but some have private reservations. Even if they agree with the principle, they may point to a great deal of evidence suggesting community care does not always work out so well in practice as in theory.

Sociologists call positive outcomes ‘functions’, negative ones ‘dysfunctions’. What, then, are the functions and dysfunctions of the communalisation of health?

Accentuating the Positive

There are at least four closely related positive functions that are served when people ‘look after their own’, rather than abdicating their responsibilities to government and to mainstream medical practitioners.

The communal comfort zone
In the first place, it is more reassuring to be looked after by people like ourselves, in familiar settings, than to be wrenched out of our personal comfort zones and handed over to the impersonal ministrations of strange people in an alien environment. When ill or injured, we are at our most emotionally vulnerable. It aggravates our original health condition if we are abruptly torn away from those with whom we feel at home. We want to be treated as full human beings, not just as sick objects by medical practitioners belonging to communities quite different from our own. It is people ‘like us’ we need around us, who share our own experiences, social situation and world view, and who therefore understand and respect our identity. It is precisely such understanding and respect that the psychiatric establishment has not always shown
towards people with mental disorders, the Pakeha health establishment has not always shown towards members of other ethnic groups, and which male doctors have not always shown towards female patients.

**Social capital**
In the second place, the voluntary sector constitutes a massive reservoir of human resources (or ‘social capital’, as these are sometimes termed) that we can tap into when unwell. Whether we are talking about young kids with the flu, old folk with senile dementia, or everyone in between, the bulk of the care work typically falls to unpaid family members – usually women. This always has been, and will always remain the front line of health provisions, no matter whether the government be left, right or centre. There are simply not enough professional medical practitioners around, nor enough money to pay them, to take on all but a fraction of routine caring. In a way, debates about the philosophy of community care are somewhat academic: in practical, everyday terms community care is simply a ubiquitous fact of life.

At another level, activating community networks is one of the most effective ways of disseminating and reinforcing public health campaigns. Government may employ punitive legislation and exhortatory media campaigns to try to stop people smoking or drink-driving, but the messages tend to get across better if communities take them on board at the grass or flax roots and monitor the behaviour of their own members. Peer pressure is one of the most effective ways of modifying human behaviour. Black looks and snide comments from family, friends and work mates are more likely to make me quit smoking than heavy tobacco taxes and MOH warnings. I may ignore the police telling me it is not okay to drink and drive; I am far less likely to ignore the disapproval of ‘significant others’ in my immediate vicinity.

**Forging community solidarity**
A third positive function of community care is to affirm the collective identity and strengthen the solidarity of the community itself. One important factor in forging a community in the first place, in binding it together once in existence, and asserting its collective mana is to get people involved in a shared project. Having a common goal to which to aspire, and a programme of action through which this goal is to be achieved, is a powerful agent in the process of community building. The mutual promotion of good health is one such project. As we have seen, it played a major role in the women’s health, the tino rangatiratanga and the mental health users’ movements, where self-empowerment in health matters became a flag around which to rally. There is nothing like fighting for a common cause with like-minded sisters, whanau or survivors to give group members a sense of purpose and fulfilment. In-group solidarity, with the accompanying boost to the personal identity of individual members, is further enhanced when the struggle is conducted against those perceived to be hostile outsiders, such as patriarchs, Pakeha or psychiatrists.

**Warding off social isolation**
The fourth and final positive function of community life for health is a more generic one. We are not talking here about any one particular community, like a specific Māori health trust, women’s health collective or network of psychiatric survivors, but of communal relationships generally. People appear to be healthier in body and (more particularly) in mind when they are integrated into warm, supportive groups than when they are isolated social particles. The determinants of good health are complex
and tangled, but there is more than straight biology involved. Our emotional states have an unquantifiable but important role to play, and these in turn are inextricably bound up with the quality of our relationships with those around us.

On the purely practical level, if we are well integrated with the significant others in our environment, we are likely to receive more and better care than if we are struggling along on our own. There is more to it than that, though. A meaningful sense of belongingness in itself plays a positive part in our overall sense of well-being. People with cohesive communal bonds are less likely to get sick in the first place, are less distressed by their illness and more likely to make a recovery than those who are socially isolated. This is particularly true for those experiencing mental disorders, but it applies to physical conditions as well. Stress is a major contributing factor to poor health of all sorts. A sense of belongingness goes a good way to keeping stress at bay, along with its associated pathologies of mind and (to some extent) of body. Healthy communities make for healthy individuals.

Negative Aspects of Community Care

Although community care clearly has its merits, both for sick people and for communities themselves, it is not always a bed of roses. There are quite a few thorns as well. Often these do not come so much from the underlying principle so much as the way things turn out in practice. In the words of the poet T. S. Eliot: ‘Between the conception and the creation falls the shadow’.

We saw this shadow when looking at the deinstitutionalisation of psychiatric patients. Everyone agreed the old mental hospitals were pretty dehumanising places, and that it would be better for people with mental conditions to be cared for out in the community. Unfortunately, it was unclear precisely where and what this ‘community’ was, with the result that services were not adequately planned, resourced and integrated. Too often, users were dumped out of the institutional rubbish bin into the social gutter.

That, however, is ground we have already covered. In the remainder of this section, four other potentially dysfunctional aspects of community care will be briefly mentioned. Each is the down side of the positive functions outlined above.

Preferring professionals to family members

When listing the benefits of communal provisions, we suggested that people typically feel more comfortable when they are with their own kind, particularly when they are mentally or physically vulnerable as a result of illness or injury. The reverse may be the case, however. We might well prefer to be cared for by dispassionate, professional outsiders rather than by those with whom we have close personal bonds. For instance, care work often involves the sometimes humiliating functions of bladders and bowels. We may find it much less embarrassing to have a catheter inserted, enema administered or bedpan emptied by those who regularly do these tasks as part of their paid jobs, than by a family member. Similarly, the nakedness of patients is a routine matter for nurses, but an emotionally fraught violation of decorum amongst family members. On a quite different front, mental disorders are frequently caused, or at least complicated, by the intense, hothouse relationships within the family or amongst
friends. If there is a breakdown in these relationships, the last people we want looking after us are those whom we may blame for our condition in the first place.

As for self-help groups, such as those formed by mental health consumers, these are by no means everyone’s cup of tea. Just because you have clinical depression does not automatically mean you want to spend your whole time with others in the same state. On the contrary, part of your desire for recovery may involve fighting your way out of the ‘tribe of the mad’ of which you have become an involuntary member. To take yet another example, if you are an urbanised, de-tribalised Māori, with no knowledge of the language and no particular interest in traditional customs, having a dentist speak to you in Māori, or chanting karakia over you, is not going to do much to cure your toothache. For a variety of reasons, then, it is sociologically unwise to assume that people always and everywhere feel most comfortable with their own folk.

**Lack of resources**

The second merit of the community listed above was that it provided a vast reservoir of free care providers, and networks through which the public health gospel could percolate. The problem here is that even though relatives and friends may be perfectly willing to help their ill or injured members, they may simply not have the technical know-how. Routine nursing of kids with the flu is one thing, but many conditions require the expertise of trained medical practitioners, not to mention clinical technology, lab tests and properly prescribed medication. Most lay people would not even be able to set a broken leg, much less diagnose a disease and prescribe the best remedy. In many situations, medically unqualified amateurs cannot and should not take over the doctor’s role. When they do, they frequently cause more harm than good by practising folk remedies passed down in the family or picked up on the grapevine.

As for the role of peer pressure in fostering safe and healthy life styles, this can work in reverse. Our significant others can actively encourage us, by example, by persuasion, or just because ‘it’s the thing to do’, to ingest dangerous substances, drive recklessly, have unprotected sex, refuse to have a cervical smear test, or whatever. The community is a great persuader, but does not always use its influence wisely.

**Capture by activists**

Our third plus for community health care was that it contributed to communal spirit by giving members a flag around which to rally, and a collective project on which to work. The unfortunate underside of this is that on occasions the flag and the project are captured by those for whom health is only a secondary interest. Community leaders and activists may use the rhetoric of altruism, but may operate by a more self-interested agenda. Community health in such cases is an alibi for the pursuit of other causes.

For one thing, certain community health crusaders are motivated more by a drive to promote themselves than the wellness of others. As mentioned earlier, a great deal of human action is driven by a hunger for mana – one translation of which may be ‘self-importance’. People with no particular distinction in their own right can achieve a certain celebrity status by identifying with the cause of the downtrodden. They become the self-appointed spokespeople for categories like women, Māori or psychiatric patients, even though nobody has elected them to these positions, and even though their sometimes extreme views are not shared by those they claim to
represent. In even more cynical cases, ostensible dedication to community health masks naked material self-interest. Every now and then, a news story hits the headlines about groups or individuals who have achieved positions of trust within an NGO, then abused it by siphoning off state grants or contracts into their own pockets.

A problem of a different kind occurs when community activists may be more interested in practising the politics of identity than in actually helping people overcome health problems. In some Māori quarters, for example, the main cause that is being promoted is Māori sovereignty. Health is just one of many cards that are played. This leads to such ideological assertions as that Māori would enjoy better health if they spoke the language, observed marae protocol, held traditional religious beliefs and enclosed themselves in iwi enclaves. These may be entirely appropriate for some Māori people, but may be quite irrelevant to others to whom being Māori or not being Māori is less of an issue than breaking out of the poverty trap.

**Community abuse**

The final entry in the debit side of the ledger balances our earlier observation that belonging to a well-integrated community can in itself act as a buffer against poor health. While this can be true, it is also true that communities may seriously undermine their members well-being, or mistreat them when ill. New Zealand has the fifth worst rate of child abuse out of 27 OECD countries. As well as physical maltreatment, a great deal of psychological cruelty takes place within the bosom of the community. Far from communal life being a warm, supportive cocoon in a hostile world, it may itself be a hell from which its victims urgently require rescuing. Communities are crucibles of both personality creation and personality destruction. As sociologists, we must be clear-eyed in recognising their dysfunctions along with the positive contribution they make to individual health.
SECTION SEVEN: CULTURE

We have now reached the final sphere of the social map. Culture is at the furthest remove from our starting point in nature. Indeed, it is the possession of culture which most clearly marks our species off from all other life forms. They live almost entirely in nature. We have much the same biological infrastructure as other species, but we shape and control it, as other animals do not, through the knowledge, values, beliefs, rituals, styles and language we learn from culture. When we talk of human nature, we inherit the ‘nature’ part from biology, but learn the ‘human’ part through interaction with our cultural environment.

Culture tells us what is true and false, what is good and bad, what is pleasant and what distasteful, what is sacred and what profane. All this is acquired through systems of signs – that is, things which stand for something other than themselves – of which the most important is language. Culture is always and everywhere acquired through the learning of such signs and their meanings. It is never directly given through first hand experience.

We look out onto the world, and we also perceive ourselves, through lenses constructed by culture. What we like to think of as ‘reality’ is actually a view of the world created by those lenses. Since different people wear diverse cultural spectacles, they possess quite different versions of reality, all convinced that theirs alone is the true one.

One of the most important jobs of sociology is to make people aware that those lenses exist, and that what may be true for them is not necessarily valid for others. We shall set about this task (which is sometimes called ‘deconstruction’) by focusing mainly on just one area of culture – knowledge. How do we go about acquiring the information through which we understand and control the natural world? Most of this section will be a Beginner’s Guide to the Sociology of Knowledge.

The Sociology of Knowledge

Culture contains a vast reservoir of knowledge, which each generation learns from the previous one, then adds to and passes on to the next. Such knowledge comes in three guises. First of all, there is an almost infinite stockpile of facts - little bits and pieces of information. Second, there are theories – explanations of how the facts fit together. Third, there are techniques – ways of getting things done.

There are a few specialist terms relating to knowledge which will crop up throughout our discussion. We try not to burden you with too much jargon in this course, but it is advisable to familiarise yourself with the following expressions, so that when you come across them you will know what is being talked about. They are:

- Epistemology
- Paradigm
Discourse

Ideology

Master or meta-narrative.

Epistemology
Epistemology is the branch of philosophy devoted to how humans acquire and validate knowledge. It asks questions like: ‘How do I know what I know?’; ‘Why do I believe what I believe?’; ‘What is Truth – and how do I recognise it?’ Just about everything you read in the rest of this section involves such questions, so it is just as well for you to have the word ‘epistemology’ in your academic vocabulary when you refer to them.

There are three other technical words you need to know, but here we strike a slight problem. ‘Paradigms’, ‘discourses’ (adjective: discursive) and ‘ideologies’ are extremely slippery concepts to pin down. Each has a range of diverse meanings, even when employed within one discipline such as sociology. To compound the problem, separate academic disciplines use the terms in quite distinct ways. It all gets very messy. Even so, these are useful terms, so we had better try to make sense of them.

For our present purposes, we will actually treat paradigms, discourses and ideologies as being more or less interchangeable. This is justifiable, as although they occupy three different countries, there is a large area of common ground where their frontiers overlap. It is on that common ground where their meanings converge that we shall concentrate. In particular, three points of similarity will be emphasised.

Paradigms: interpretive frameworks
Paradigms are the cultural lenses referred to earlier, through which we perceive and interpret part or all of what we believe to be reality. We could also call them worldviews, conceptual frameworks, explanatory models, templates, blueprints, patterns or principles. Whatever the name, they set up the rules through which Truth with a capital T is established, and they banish all rival claimants to Truth. For fundamentalist Christians, to give just one example, the Bible contains such a paradigm. Everything in life must be interpreted according to its sacred words. All else is heresy.

Discourses: situated points of view
Our second observation homes in on something crucial that those who construct systems of knowledge seek to hide from us. This is that although they claim to be laying down universal laws, in fact they only speak from one point of view. Their ‘truths’ are always situated in one specific place in history and in one particular society. This is what is implied in the term ‘discourse’. It suggests that what is being said or written represents just one opinion amongst a host of competing voices. Thus, when we deconstruct discourse, we are not so much interested in what is being said as in who is saying it, and why.
Ideologies: power games

Another thing which regimes of alleged Truth try to conceal is that behind their mask of objective neutrality they are actually engaged in power struggles. This is particularly relevant for the term ideology, which may be defined as: ‘The manipulation of culture in the service of power’ – although the same definition could actually apply equally to discourse. If I can brainwash you into believing that my version of ‘reality’ is the absolute Truth, and thereby get you to see the world the way I want you to, obviously I will have a good chance of bending you to my will without needing to raise a finger. I will have mind control over you, which is far more effective than the use of naked force, and much cheaper than buying your acquiescence.

In the above explanations, we tried to bring out slight differences in the three terms. When using ‘paradigm’, the main focus is on the rules for establishing Truth. With ‘discourse’ it is on the situated speaking voice hiding behind the rules. With ‘ideology’, we are unmasking power games. Despite these differences of emphasis, the three concepts converge on common ground, in that they all help us to deconstruct interpretive lenses which purport to reveal reality but whose pretensions to knowledge are actually limited and partisan.

Master narratives or meta-narratives

Another useful term that means much the same thing as paradigm, discourse and ideology is ‘master narrative’ or ‘meta-narrative’. A master narrative is an overarching account of the world which explains everything from the meaning of life to the fall of a sparrow. Meta-narratives are the biggest ideologies, discourses or paradigms of all. They include every shape and form of religion, but also secular myths like liberalism, communism, nationalism and a whole host of social movements.

You have now been furnished with a tool kit of handy concepts and definitions. What, you might say, has all this to do with the central topic of this module – health? As a preliminary answer, it might be useful to track all the way back to the section on Nature with which we began, and repeat some observations that were made there. Here is what was said:

What ensues once we consult a medical practitioner is an epic struggle between nature and culture. On the one hand there is our wayward biological organism, on the other the cultural expertise through which our pathology is interpreted and cured. Unlike all other life forms, which must cope with illness and injury as best they can from their own natural resources, humanity has a unique ally in the vast storehouses of knowledge that have accumulated in the cultural domain down the epochs. It is culture which supplies the theoretical explanations of how illness is caused, and it is again culture that furnishes the technical know-how to heal it.

Cultures differ, however, in their approaches to health issues. One of our major tasks as sociologists of health is to explore the diverse ways that cultures in different ages and societies have gone about constructing their causal theories of illness, their diagnostic techniques and their therapeutic practices. All three of these are cultural, but they vary immensely from epoch to epoch, and from one society to another. Sociology’s role, amongst other things, is to highlight the differences and explain their significance.
The time has come to pick up on the above brief comments from the *Nature* section and explain their significance to contemporary Aotearoa/New Zealand.

There are three rival meta-narratives about the causes, diagnosis and treatment of illness on offer. We will mainly call these the ‘biomedical’, ‘alternative’ and ‘supernatural’ discourses, although they can be called by a variety of other names as well, which will be introduced as we go along. There is also a fourth category, which we will term the ‘lay’ approach, which is not so much a paradigm in its own right, as a mish-mash of the other three. We will work our way through each in turn, starting with the most systematic discourse – that of biomedicine – and ending with the most chaotic i.e. lay approaches to healing.

**The Biomedical Approach**

The biomedical approach, which can also be termed ‘science-based medicine’ has been the dominant discourse in health matters for at least the last 100 years. Indeed, it has become so authoritative it may be justifiably called ‘orthodox’, ‘conventional’ or ‘mainstream’ medicine. Its front-line practitioners are medically trained professionals like doctors, nurses and physiotherapists, backed up behind the scenes by technical experts such as radiologists and pathologists. All orthodox medical practitioners, particularly doctors, have to be accredited through a long, rigorous course of education in their discipline, and their developing competence on the job is monitored by senior colleagues and by their professional organisations.

In the background there looms what might be called the international medical science industry, in which researchers and business entrepreneurs collaborate in the discovery and manufacture of medical technology and drugs. These are quality controlled by government agencies, and pharmaceuticals cannot be released to the public till their safety has been rigorously checked.

The whole edifice of conventional medicine is underpinned by an epistemology (i.e. theory of knowledge) sometimes called ‘positivism’. Positivism is based on the premise that the only valid way of discovering the truth about anything – including human beings – is through the meticulous application of the scientific method. The only true knowledge is that which has been discovered and verified through science: everything else is mere ‘belief’.

Positivism requires the rigid application of several inter-related principles and procedures. One is that to provide us with hard knowledge, phenomena must be empirically observed, described and measured. Medicine, for instance, must be based on a detailed and accurate understanding of human anatomy and physiology. Another core principle is that science must be based on proven laws of natural cause-and-effect. A third is that all facts and theories must be objectively verified by experts in the field, ideally through experiments which others can duplicate. Where laboratory experiments cannot be performed (which is frequently the case in human medicine) statistical research should be conducted to check out scientists’ assertions. The importance of the principle that knowledge has to be objectively verified and validated can be seen by the constant stress placed in the Ministry of Health on what is termed ‘evidence-based’ practices. Health providers cannot get away with intuitive
hunches and vague speculations about the efficacy of what they do: it has to be backed up by hard evidence.

The point of these procedures is to eliminate error. Medical science only deals in propositions that can be ‘falsified’. This is what differentiates scientific knowledge from mere belief: the former can be proved wrong, the latter cannot. Popular opinion to the contrary, positivism is a very humble form of epistemology, as it is constantly vigilant to the possibility of making mistakes. Scientists are aware that they can ‘get it wrong’, and have built this awareness into their methodology.

Medical science regularly admits and corrects its own poor judgement calls. A recent case in point was its acknowledgment that replacement hormone therapy for women going through the menopause, which had been thought an almost infallible way of warding off old age, was actually harmful in a statistically significant number of cases. Or again, it was eventually recognised by psychiatrists that the anti-psychotic drugs they once prescribed so liberally for people with serious mental disorders were often doing more harm than good. The point we are making with these examples is not so much that science made mistakes, as that it recognised and addressed them. This, in fact, is how scientific knowledge makes progress – not by claiming to be infallible, but by having a self-correcting principle built into its methodology. This is what distinguishes scientific knowledge from belief, which never opens itself to the possibility of being proved wrong. Belief is dogmatic, science is not. Science makes progress, belief stays still.

The Medicalisation of Everyday Life

Despite its publicly acknowledged mistakes, biomedicine has gained increasing ascendancy over people’s minds and bodies over the last century or so. That is why we are justified in calling it a master narrative, dominant discourse and so on. Many areas of human life which once lay outside the domain of medicine have now been incorporated into it, through a process known as ‘medicalisation’.

Medicalisation occurs in a variety of different ways and contexts. For one thing, scientific medicine has largely taken over from (and attempted to discredit) rival forms of healing. Like Jehovah, medical science has been a jealous god, sternly discouraging worship at any therapeutic altar than its own. There will be more about this shortly.

Using the term in a rather different sense, medicalisation refers to the populace’s growing conviction since the 19th century that biomedicine is an almost magical fix-all. If we or people close to us are afflicted with a horrible condition like cancer or AIDS, we cling to the faith that modern medicine will come up with a cure before it is too late, where we would once have pinned our hopes on the intervention of a benevolent deity. ‘Science can perform miracles’, we murmur with as much conviction as we can muster.

We are regularly encouraged to keep our faith in the magic bullets of biomedicine alive by news headlines every few weeks about yet another miraculous scientific breakthrough, promising relief from one or other incurable disease. The subsequent story usually reveals that the ‘breakthrough’ was really only the tentative findings of
one experiment on white mice, whose relevance for humans – if any – would only be revealed at some unspecified time in the future. Nevertheless, the fact that a news editor thinks this merits a headline is itself symptomatic of our need to believe in the efficacy of the biomedical paradigm.

The same medicalisation can be seen in more mundane matters, not just issues of life or death. There are a whole host of physical conditions, and sometimes emotional ones as well, which our forebears would have just stoically accepted as unavoidable parts of their lives, but which today we hope – even demand – medicine to fix for us. We would feel more at home in our bodies, and more attractive to others, with different sized noses, breasts, buttocks or whatever, so we turn to a plastic surgeon to re-design us. Rather than resigning ourselves to the growing bodily decrepitude of old age, we have our wrinkles removed, our faces lifted, our hormones replaced and so on. Rather than cutting down on food and drink, we have our stomachs stapled. If we cannot conceive children, we turn to medical scientists to do the job for us in a test tube. If haunted by melancholy, we swallow an anti-depressant. If insomniac, we pop a sleeping pill. To avoid possible complications in labour, we opt for a caesarean birth. The list could go on, but the point is clear. There are a myriad of things which in former times people just accepted as part of the unpleasant round of everyday life. Now they turn to Dr Fix-it.

In yet another domain, the term ‘medicalisation’ can refer to the ways in which moral or religious judgements of former times have been replaced by medical ones. In the process, our attitudes toward people with certain conditions, along with our behaviour towards them, has undergone a change. They are no longer regarded as objects of ethical or spiritual value judgements, but patients in need of treatment.

Homosexuality is a good example of this. Up to the 20th century (and still today in many circles) erotic love between members of the same sex was regarded as both a religious sin and a perversion of nature. Homosexuality was abominated and homosexuals persecuted. At some point last century, however, social attitudes softened a little, in the West, at least. Homosexuality was downgraded from a sin to a form of mental illness, for which its ‘sufferers’ could seek medical help. Since then, the wheel has turned even further, and being ‘gay’ has been demedicalised again, now being regarded, in liberal quarters anyway, as simply one amongst many varieties of human identity. From our present vantage point, defining gays as mentally ill seems inappropriate and insulting, but in its time it was a progressive move, as it transferred them from the stigmatised category of sin to the morally neutral zone of illness. Being regarded as sick rather than sinners was not a great advance in itself, but was at least a step in the direction of acceptance.

In another domain, children whose disruptive and anti-social behaviour would until recently have been defined as ‘naughtiness’ are now diagnosed with attention deficit and hypoactivity disorder (ADHD) and prescribed medication. Or again, alcoholics and gamblers today are not regarded as weak-willed ratbags, but victims of mental disorders calling out for sympathetic treatment. In such instances, medicalisation has the merit of rescuing people from moral opprobrium. They are no longer labelled deviants but are installed instead in the more comfortable sick role.

**Challenging Medical Hegemony**
The above manifestations of medicalisation are just specific instances of a more general feature of modernity. It was an epoch in which more and more of the general populace turned to scientific medicine and its white-coated representatives where once they would have turned to religion. It offered secular redemption from pathology in place of spiritual salvation from sin. The obvious corollary was that the general public were subjected to ever more surveillance by the medical profession. From the time an embryo was conceived till the hour came for a doctor to write out an official death certificate, the medical gaze was upon them. Most people wanted this – who doesn’t want to be healthy? – but they also came to resent the hegemony medical science had gained over their lives. Consequently, by the start of the present century the biomedical paradigm still ruled the health roost, but its authority was being challenged, and its status was a little tarnished. The rebellion against medical positivism has already been fairly extensively discussed in previous sections, so here we shall just provide some quick reminders of what was said earlier and a few more brief examples.

For one thing, the medical establishment seems particularly prone to Murphy’s Law (if something can go wrong, it will). Despite what was said earlier about the self-correcting nature of science, the fact remains that in practice it makes many blunders, as do the bureaucracies that administer it. Medical misadventures, ranging from mistaken diagnoses to surgical bungles, happen far too frequently. Furthermore, until the last ten years or so, those at the receiving end had few avenues for complaint or redress. Blunders could even happen on the grand scale. A classic example occurred a few years ago when a Gisborne pathologist under-reported a large number of abnormal cervical smears, thus exposing the women being screened to the risk of developing cancer. Coming on top of ‘the unfortunate experiment’ at National Women’s Hospital, also involving cervical cancer, the Gisborne affair further eroded many women’s already shaky confidence in scientific methodology.

As well as the dodginess involved in screening for cancer, whole classes of medicines and surgical procedures can turn out to be more dangerous than beneficial. Two instances have already been given – the discovery that hormone replacement treatment and entire generations of mood-controlling drugs could have extremely harmful side effects. At a more everyday level, the experts constantly change their minds about what is and what is not good for us. We conscientiously avoid eating and drinking certain things, only to discover a year or two later that they are actually beneficial. Conversely, we tuck into food and drink that is supposed to make us healthy, only to learn subsequently it is toxic. We want to have faith in medical science, but it doesn’t make it easy for us when today’s wisdom regularly turns out to be tomorrow’s claptrap.

On quite another front, whole categories of people have started to resent what they perceived to be the arrogance of doctors, their insensitivity to the all-round humanity of their patients, and the power they wield over their lives. This is particularly the case if the doctors happened to be of one class, gender and/or ethnicity, their clients of another. Working class people can feel patronised by middle class professionals, Māori and Pacific Islanders by Pakeha ones, women by males.
Sometimes this amounts only to a sense of personal irritation at being condescended to. In some circumstances, however, it involves more than individual exasperation at condescending attitudes. Through their key positions in the welfare system, doctors have the structurally-conferred power to affect the lives of large numbers of people dependent on that system. They are what sociologists term ‘gatekeepers’. They hold the keys that will open or close the gates into non-medical services we may badly require. For instance, there are a range of state benefits, grants and exemptions for which ‘the sick role’ makes us eligible, such as receiving the Invalids Benefit instead of being obliged to get paid work. It is typically doctors who pronounce on our eligibility for these benefits. No matter how dispassionate and fair their assessments, the very fact that medical practitioners have such power over people’s lives may in itself be a source of resentment against them.

There is a final ingredient to add to the mix. It sometimes goes by the German word ‘zeitgeist’, which can be translated as ‘the spirit of the times’. The zeitgeist of our own age has a distinctly anti-scientific flavour to it. This flows from at least four quite different sources:

- New Age romanticism
- Religious fundamentalism
- Ethnic politics
- Feminism.

On the New Age front, in the 1960s hippies proclaimed the dawning of the Age of Aquarius – a beautiful new world, where material values would give way to spiritual ones, duty to pleasure, commerce to art, puritanism to sexual liberation, the city to nature, the individual to the commune and so on. In short – New Age. Hard-nosed positivism was one of the targets for this surge of romanticism. People wanted softer, gentler, more holistic forms of healing.

At the same time, science came under attack from a quite different direction – Christian fundamentalism. A strong religious revival, based on a return to the literal interpretation of the Bible and inflamed with charismatic zeal swept out of the United States. It was avowedly anti-scientific in epistemology, opposing widely accepted secular theories, notably that of biological evolution, with the allegedly superior knowledge contained in God’s own sacred words. Back in the 19th century, the discourse of science had mounted a major and largely successful attack on religious ideology. Over the last half-century, religion in a particularly fundamentalist form has counter-attacked. The very foundations of evidence-based knowledge have been radically queried by those for whom truth resides in emotionally intense belief rather than dispassionate investigation. Positions which science thought it had definitively won generations ago are again being hotly contended.

The third challenge to the hegemony of science-based medicine has come from a resurgence of ethnic identities in our post-colonial world. Indigenous people like the Māori in Aotearoa have begun to reassert their own traditional cultures in the face of Western biomedicine. The latter is perceived by some ethnic minorities as just one
manifestation amongst many of an alien and oppressive world view forced upon them by the arrogance of white colonisers. The struggle to re-establish their own mana is accompanied, in some quarters, by renewed interest in traditional medication (‘rongoa’ in Māori) and in supernatural forms of healing that had been driven underground by the supremacy of Western medical practices. The renaissance of old methods of healing is embodied in the organisation Nga Ringa Whakahaere O Te Iwi Māori, which advocates for the inclusion of rongoa in the state-funded health system.

Some strands of feminism, too, have played a part in the questioning of orthodox biomedicine. It is not a defining characteristic of all feminism, but in certain circles Western science and the positivist epistemology on which it is based has been equated with patriarchal power and challenged accordingly. The home birth movement and the associated re-emergence of domiciliary midwifery, allegedly more natural and holistic than hospital-based birthing, is an obvious example.

At the very start of this module, you were advised to keep an eye out for the many appearances of that all-important concept ‘power’ in its pages. What we have been just saying about contemporary challenges to biomedicine is a classic illustration. Back in the 1950s, it looked as though orthodox medicine pretty much had the field to itself: it was the way of the future. Since then, its power over people’s minds and bodies has been challenged on at least four fronts – New Age philosophy, religious fundamentalism, the politics of ethnic identity and certain forms of feminism. The resulting power struggles are not just superficial scraps over the best way to set broken bones or whatever. They engage with the most basic of all cultural issues, summed up in the ultimate epistemological question: ‘What is Truth, and how do I find it?’.

Having established the philosophical issues at stake, let us now turn our attention to the more immediate question of how these debates manifest themselves in practice. If people mistrust scientific medicine for one reason or another, to whom do they turn when their bodies or minds start playing up? The time has come to introduce biomedicine’s rivals.

**Alternative and Complementary Medicine**

Our second brand of healing today sails under the flag of ‘complementary and alternative medicine’ (CAM) or else ‘complementary and alternative health’ (CAH). Strictly speaking, this is not one unified paradigm like positivism, but a whole hotch-potch of contending discourses and practices. What they all have in common, and what justifies putting them together in the same basket, is a shared suspicion of orthodox Western medicine. For a whole variety of reasons, they believe there are better ways of healing than those offered by hard-nosed biomedicine and its formidable array of synthetic chemicals, dehumanising technology and scalpel-wielding surgeons. The five most widely known and used techniques are acupuncture, chiropractic, osteopathy, homoeopathy and herbal medicines. However, there are a vast range of other alternatives on offer, including aromatherapy, colour therapy, massage, hypnosis, crystals, iridology, primal screams, vitamin and mineral supplements, patent pills and potions, dietary and exercise regimens, immersion in water, touch-for-health, the removal of dental fillings... the list could go on.
These are only ‘alternative’ forms of diagnosis and treatment in relation to the current biomedical paradigm. Before that rose to dominance a century or two ago, what we now call alternatives were typically the only things on offer. Furthermore, the forerunners of today’s orthodox doctors, with their humours, their purges, their bleeding cups and leeches, would themselves now be regarded as dangerous cranks. Thus, what is now alternative was once mainstream, and what is now mainstream was once muddle-headed. What is more, techniques like acupuncture, which have only recently begun to be accepted as legitimate in the West, were – and still are – regarded in civilisations like China as mainstream (as, for that matter, are a whole range of natural remedies which to Westerners are quite beyond the pale). Our point is that whether or not you regard a practice as alternative depends upon what moment in history and which culture you are looking at.

The fact remains that once science-based medicine began spreading its sphere of influence, it did so at the expense of alternatives to it. Just as millennia ago monotheism declared war on pagan idols, so biomedicine established its dominance by discrediting rival therapies.

It often had good reason for this. Right into the 20th century, the credulous populace were preyed upon by quacks peddling patent medicines which had no healing powers whatsoever, and were usually laced with opium or alcohol to produce a quick ‘feel-good’ effect. Even when not cynically promoted for purely commercial ends, the ingredients of homespun medication justifiably caused the nascent medical establishment to raise its eyebrows.

For instance, this country’s most famous herbalist, Suzanne (Mother Mary) Aubert, who made extensive experiments with Māori rongoa, prescribed the following for asthma: ‘Gather snails while the dew is still on the plants in the morning; crush and put equal parts of vinegar and water; stand twenty-four hours, drain off liquid and drink’. (http://www.hoc.org.nz/Suzanne_Aubert/Publications/Rongoa.htm).

Suzanne Aubert’s career as an alternative healer illustrates the pitfalls surrounding the promotion of many patent medicines. She began with a sincere desire to blend the traditional herbal remedies she learned in France with local ones she learned from Māori women up the Whanganui river. However, to earn money for her Roman Catholic mission, she patented a mixture and licensed it to a firm for commercial production. In its heyday, it was selling over 30,000 bottles a year, accompanied with an advertising blitz that turned the nun into a national celebrity. In the process the medicine was adulterated, began fermenting in its bottles and had to be pulled off the market. What began as a genuine desire to heal degenerated, through no fault of Mother Mary herself, into charlatanism on the grand scale.

It was scarcely surprising, in the face of such commercial exploitation of public credulity, that the apostles of scientific medicine intervened, through pieces of New Zealand legislation like the 1908 Quackery Prevention Act.

Around the same time, Māori doctors in the Young Māori Party, like Maui Pomare, were equally suspicious of traditional remedies prescribed by tohunga, which they regarded at best as being ineffective against imported European diseases, at worst as...
being straight charlatanism. Their opposition was given legal expression in the Tohunga Suppression Act of 1907. In the 1920s, similar hostility to the alleged quackery practised by Māori tohunga figured largely in the message of the Māori prophet Wiremu Ratana (although he himself laid claims to magical healing powers).

Revival of Alternative Medicine

Whatever the rights and wrongs of the matter, by the middle of the 20th century most rivals to orthodox medicine had been driven into the margins of the health system. However, since the 1960s alternatives of all sorts have made a remarkable comeback, for reasons explained earlier. Today, the Ministry of Health has a special page on its website devoted to CAM (http://www.newhealth.govt.nz/maccah) and has commissioned a major report on the subject from its Ministerial Advisory Committee on Complementary and Alternative health (MACCAH). On the financial side, some forms of alternative therapy, such as acupuncture and chiropractic, are already funded through ACC, and there is growing pressure for more state subsidisation of a wider range.

Such acknowledgment of CAM from the top of the health system is in large part a response to its widespread attractiveness to the public generally. In the National Health Report of 2002-03 for instance, about a quarter of those surveyed reported they had tried some form of alternative medicine in the previous year. Amongst other things, there is a growing interest in some quarters in the kinds of traditional Māori rongoa with which Mother Mary had experimented a century or so earlier.

What is it about alternative healing that seems to appeal to so many people? It cannot be that it is cheaper, since with a few exceptions it is not state-funded, and therefore can be at least as costly as orthodox medicine, if not more. We do not have hard answers to the question of why there has been a renaissance of alternative therapies, but we can offer some speculative suggestions.

First, it may be part of the New Age zeitgeist mentioned above. People want a gentler, more sensitive alternative to the hard-edged, impersonal ethos of biomedicine. Words like ‘natural’, ‘spiritual’ and ‘holistic’ figure prominently in the discourse of the age, and it is precisely such qualities that most alternative healers proclaim as the hallmark of their particular speciality. They deal in natural cures, as opposed to synthetic ones out of laboratories; they are in touch with their own and their clients’ spirituality, whereas science is coldly rational; they treat people as whole human beings, instead of focusing on one malfunctioning part of the body.

An extra aura of authenticity is added if the therapy is claimed as ‘traditional’, since this is redolent of ancestral wisdom. A further flavour of authenticity is injected if the approach is practised by ethnic groups other than the dominant white one. Rebelling against Western culture, some people believe as a matter of faith that non-Western alternatives must contain a superior wisdom.

However, good sense would suggest that probably only a fairly small minority seek out alternative healers solely for the motives just outlined. We tend to take health matters fairly seriously, and would probably be unlikely to totally foresewrd orthodox medicine in favour of exotic alternatives if the latter were of no benefit. Maybe we
could try them out a few times, but if the condition did not improve we are not likely to cling to crystals, acupuncture, rongoa or whatever just for its own sake. Pragmatism and practicality are probably much more compelling motives. If we take our bad back to an alternative healer and it gets better, we will return for more. If several sessions do nothing for us, we are likely to give up on it. On the whole we tend to remain loyal to a particular form of therapy for practical rather than ideological reasons. We may initially be attracted by the idea of a cure being natural, spiritual, holistic, traditional, Māori and such-like, but will probably lose interest if it does not come up with the goods.

However, there is a category of patients who seek out alternative healers not from a spirit of take-it-or-leave-it pragmatism but from desperation. These are unfortunate people with acute, chronic or terminal conditions which orthodox medicine cannot reach, such as cancer patients who have unsuccessfully undergone surgery, radiotherapy and chemotherapy. They may, in fact, turn to gentler regimens precisely to avoid the suffering and indignity involved in such mainstream interventions. In less extreme cases, people may have gone to doctors for years to get help with a bad back, dermatitis, depression or whatever, only turning to alternatives when conventional treatment fails. It is despair rather than belief that drives them to clutch at whatever straws are on offer outside the frame.

**Shortcomings of Alternative Medicine**

Many people swear by their particular brand of alternative therapy, often because it gives them relief where orthodox medicine failed. Nevertheless a cloud of scepticism hovers over the whole area, particularly amongst mainstream medical practitioners. A fascinating account of the prolonged ideological struggle between alternative healers and the medical establishment can be found in Kevin Dew’s book *Borderland Practices: Regulating Alternative Therapies*. Here, we shall just briefly suggest a few reasons why adherents of the biomedical paradigm are suspicious of alternatives to it.

At one level, opposition to CAM is a turf war. The mainstream biomedical establishment resents having its hard-won position of dominance challenged by outsiders. Professions are tribal in nature, competing for status, money and authority. They stake out territory and guard it jealously. We saw this tribalism at play in previous sections, where we discussed the three-way struggle between doctors, nurses and midwives. The standoff between orthodox and alternative healers involves the same kind of territoriality. Doctors may regard acupuncturists, herbalists and the like as poachers.

There is more to mainstream medicine’s concern about alternative practitioners than crude professional rivalry, however. By the criteria of their own positivist paradigm, the former have legitimate doubts about the credibility of the claims made by alternative healers. These doubts centre on a term we introduced earlier – ‘evidence-based’ medical practice’. CAM is considerably less rigorous in its methodology – the ways it goes about proving the efficacy of its diagnoses and treatments – than is orthodox medicine. It claims to be based on the same scientific principles of cause-and-effect as the hard sciences, but tends to be rather vague and imprecise in applying them. Positivism has a self-correcting tendency, an openness to falsification, which is frequently lacking in its alternative counterparts. Furthermore, in some cases CAM
operates from totally different models of anatomy and physiology from orthodox science. Acupuncture, for instance, is based on a Chinese theory of energy flows called ‘chi’ which do not feature in the syllabus of Western medical schools.

A related cause for scepticism is that certain forms of alternative healing make large, grandiose claims about what they can cure. They employ just one limited technique, such as massaging the soles of the feet, inserting needles, prescribing primrose oil, extracting mercury fillings or manipulating the spine, yet claim it can cure everything from warts to cancer. Such excessive claims are often backed up by self-promoting advertisements, often quoting ‘unsolicited testimonials’ from happy consumers whose whole lives have allegedly been turned around by the cure in question. Alternative healers loudly proclaim their alleged successes, seldom if ever conceding they can fail or make mistakes.

The promotional discourse surrounding CAM also employs vague but evocative trigger words, prominent amongst which are those evoking ‘Nature’. If a cure is natural, it is assumed to be unquestionably good. This association between alternative medicine and nature, however, overlooks four things. First, natural substances can poison as well as heal. Second, many of the ‘natural’ remedies on sale are actually industrially manufactured. Thirdly, a wide range of mainstream medicine is natural in origin. Finally, just because a drug has been synthetically produced in a laboratory does not reduce its efficacy. On the contrary, such drugs may hit their targets considerably more accurately, effectively and safely than their natural counterparts. CAM, then, frequently sets up a false dichotomy between its own virtuous, nature-based remedies and the disapproved synthetic ones of biomedicine.

Yet another cause for concern is that alternative practitioners do not have to undergo the same rigorous qualifying process as mainstream ones, nor are they subjected to the same on-going surveillance by their peers. Many may indeed have received a perfectly reputable education in their field, and are as thoroughly professional as their orthodox counterparts. The fact remains that just about anyone can set up as an alternative healer, and the field abounds in self-taught amateurs. Admittedly, evidence-based standards of competence are being increasingly applied to CAM practitioners, but quality control remains far less rigorous than for regular doctors and for prescription medication.

If quality assurance and monitoring of competence is somewhat sloppy at the provider end, a similar sloppiness characterises the consumption of alternative remedies. A great deal of self-dosing goes on. People hear on the grapevine that some substance, such as primrose oil, St. John’s wort, green-lipped mussels, manuka honey, vitamin C, flax oil or whatever, has miraculous powers. They buy it off the shelf from a supermarket or health food shop and tuck in. Quite apart from the validity of the claims made for it, people’s consumption of the substance in question is totally unmonitored. They may swallow large amounts, assuming the higher the intake the better the outcome. Or again, their initial enthusiasm may dwindle, especially when they realise how much they are paying, and they will take themselves off the regimen as arbitrarily as they went on it. Furthermore, there is no real way of knowing whether the substance is actually doing them any good, as often the alleged benefits are long-term ones, warding off conditions we might not get anyway. If we do notice an improvement in our health, this may just be coincidental, or may be
thanks to the placebo effect – that is, it is our faith in the pills, not their actual content, which has triggered our recovery. It is a hit-or-miss, do-it-yourself affair – a far cry from a doctor-controlled course of prescription drugs.

All in all, then, there is a large zone of uncertainty surrounding alternative therapies. The same, of course, can be said about much orthodox medicine, but the latter is at least subjected to more rigorous self-appraisal. CAM practitioners range from highly trained experts through well-meaning amateurs to cynical charlatans, out to make a quick buck by exploiting other people’s distress and gullibility. Their remedies may be highly effective, ineffective or actively dangerous. Consumers may be extremely discerning and selective, haphazard experimenters or unfortunate dupes. Probably the only epistemological judgement we can make about CAM’s claims to truth is a purely pragmatic one: if it works, it works.

Supernatural Explanations and Cures

Although alternative medicine is not as scientifically rigorous as its biomedical counterpart, it does at least acknowledge the primacy of natural laws of cause-and-effect in health matters. Our third paradigm rejects these altogether. According to what we may variously term religious, supernatural or magical discourse, physical and mental pathologies are purely spiritual in origin. Let’s remind ourselves of what was said about this back in the section on Nature:

Throughout most human history, and even today in many quarters, it has been assumed that disorders have supernatural rather than natural origins. They are caused by black magic, the violation of tapu, the anger of a god, demonic possession, lack of faith and so on. Their treatment, too, must be supernatural. Illness, in short, is a spiritual matter, not a natural one. Therefore, it must logically be cured by spiritual means. Being given a shot of penicillin is not much use if your disease was caused by someone casting a spell against you. An operation will not help your blindness if it was caused by lack of religious faith. If an evil spirit has taken over your mind, anti-psychotics will be of no avail. In short, you do not need a doctor, you need a religious expert of one sort or another, be this a tohunga, priest or faith healer.

We do not know how much magic-based healing actually goes on in contemporary New Zealand, so can only suggest the major forms it takes. Broadly speaking, it can be classified as belonging to one or a combination of the following:

- Freelance
- Prophetic
- Church-based
- Traditional Māori

By the term ‘freelance’ we are referring to the conviction possessed by some individuals that they have mysterious healing powers, usually transferred to their patients by the laying on of hands. They cannot explain this ability – sometimes it is attributed to spiritual forces, but it is not related to any organised theological
paradigm. It is just seen as a remarkable gift with which they are endowed, as others are especially musical, mathematical or whatever.

Some such individuals, however, use their alleged healing power to launch careers as full-blown prophets or religious leaders in their own right. Their miraculous power to cause the blind to see, the crippled to walk, the ill to rise from their sick beds and so on is a sign that they have been chosen by God for a special mission. Most aspirant prophets include healing in their repertoire as a way of legitimising their religious pretensions. The best-known New Zealand example is Wiremu Ratana, who claimed to have been called by God in a vision, and was said to subsequently have acquired the gift of magical healing.

In our third, ‘church-based’ category, faith healing is not the unique prerogative of one charismatic prophet but part and parcel of the on-going ethos of an entire church. Even the most conventional of mainstream congregations, such as Anglicans, regularly pray for the recovery of the ill, injured or disabled. They do not think of themselves as dabbling in magic or miracles – prayers for the sick are just part of routine church ritual. Some mystically inclined clergymen in mainstream churches, however, may be more proactive in their spiritual war on pathologies of the body or the mind. These are defined by the priests in question as the work of Satan, to be exorcised by the vigorous performance of religious rituals, usually involving prayers and the sprinkling of holy water.

The most common form of institutional faith healing is practised by the various charismatic or Pentecostal sects that have proliferated since the resurgence of fundamentalist Christianity from the 1960s. Exhortations to the ill or disabled to become whole again are a regular part of the theatrical displays at revival meetings. If such people obdurately insist on remaining ill, it is taken as a sign they lack true faith, and are condemned accordingly.

Finally, there is traditional Māori healing. Illness is diagnosed either as the result of makutu (black magic) or of the violation of sacred codes (tapu). If makutu is involved, a spiritual counter-attack must be mounted against the perpetrator, in a contest between good and bad magic. If tapu has been broken, spiritual expiation and cleansing must be undertaken with the help of a tohunga. Traditional methods are most relevant when people are suffering from ‘mate Māori’ (Māori sickness) which displays unique symptoms not attributable to known Western diseases of body or mind, and therefore must be cured through uniquely Māori methods.

The case of mate Māori is a classic illustration of the collision of two meta-narratives. Western medicine would diagnose a biological pathology and prescribe biomedical treatment. Māori see a spiritual malady and perform restorative rituals. These are the two epistemological extremes, one interpreting the world through sacred lenses, the other through scientific ones. The one gives power to priests, evangelists, tohunga and theologians, the other to scientists, technicians and doctors. In between, with a foot in both camps, lies the domain of alternative and complementary healing. It bows in the direction of positivism, since it usually explains its methods in terms of natural laws of cause-and-effect, yet its efficacy often depends more on belief than knowledge. All three lay claims to ownership of Truth, all three secretly covet power. It is only when they are laid side-by-side that the discursive and ideological nature of
their paradigms becomes apparent. Each constructs its own version of reality in order to enhance the wealth, power and status of those who practise it. They all may well be sincere – but sincerity is a quality of which sociologists must be sceptical.

Lay Approaches to Health: Eclecticism and folk remedies

Up till now, we have been discussing the health paradigms of those who do the diagnosing and curing. What about the majority of us who are on the receiving end of their expert wisdom? How do lay people – men and women in the street – play the health game?

In the first instance, people tend to buy into the dominant discourse of their place and time – the one with which they are most familiar. Throughout the 19th century, for instance, most Māori probably felt more at home with a combination of religious rituals and traditional rongoa rather than with the newfangled Western approach. Today, the dominant paradigm is biomedicine, and the majority of New Zealanders, including Māori, would probably initially place their trust in doctors, rather than alternative therapists and faith healers.

That said, a great deal of mixing and matching goes on. We may start off with our GP, but if we get no satisfaction there, we are likely to try a CAM practitioner, particularly if other people sing his or her praises. If we still do not get better, we may try out faith healers. Of course we may work in the opposite direction, starting off with alternative or religious healers, then deciding it might be wiser to go to a regular doctor, especially if the condition is serious or we suspect the alternatives are frauds.

Sometimes, just to be on the safe side, we run two or three in harness. After all, our main concern is getting well. Unless we have particularly strong ideological preferences for one paradigm over others, we are willing to give them all a go. In short, we tend to be pragmatic. We are not all that interested in theory or theology: we just want what works for us.

We are sometimes helped in this eclecticism by the fact that practitioners themselves may be relaxed about their rivals, even taking an interest in their methods. An increasing number of orthodox doctors, for instance, have taken up techniques like acupuncture, not necessarily because they believe in its metaphysical underpinnings, but simply because in some cases it is effective. On the other hand, alternative therapists with integrity and good sense will be aware of their limitations, and advise their patients to see a regular GP if the condition is too grave for them to handle, or is outside their sphere of competence. Thus, although we have presented the three paradigms in separate compartments, in real life it is seldom an either/or affair. Lay people shop around.

They are increasingly able to do this as ever more information about health matters comes their way. They pick up ideas from family and friends, from magazines, news stories and talkback radio. They also do their own proactive research on the internet, which offers advice, both useful and useless, on every medical condition under the sun. No one expert is regarded as the fount of all wisdom. We probably pick up far
more knowledge about our illnesses from a mixture of free-floating information (and misinformation) than we do from our GPs.

A large part of that free-floating mixture comprises what we might call ‘folk remedies’. These do not belong to any of the three major paradigms. They are just quirky cures and precautions we hear about on the grapevine, or which are passed down in families from generation to generation. They often roll over the country in fads or fashions. For a year or two back in the 1950s, for instance, many Kiwis were convinced you could ward off car sickness by clutching a lemon. Cars throughout New Zealand exuded a strong citreous smell – till lemons were replaced by a new craze for trailing chains from the back bumper bar. Turn on talkback radio any time, and you are bound to pick up a whole swag of such folk remedies. The medical advice dispensed by doctors in their consulting rooms is only a drop in the ocean of folklore in which the general populace floats.

‘Is’ versus ‘Ought’: Medicine and Ethics

Most of this section has been devoted to just one dimension of culture – knowledge – and to the collision of two paradigms, one based on scientific positivism, the other on belief in the supernatural, with alternative healers occupying the middle ground. In these final pages, we shall briefly explore a culture clash of a different sort. It requires introducing into our discussion the second dimension of culture mentioned at the start, termed ethics or morality. Knowledge tells us what ‘is’; morality tells us what we ‘ought’ to do. Knowledge instructs us in what is true and false; morality instructs us what is right and wrong. There are many occasions when ‘is’ and ‘ought’ come into conflict.

Biomedicine has conferred on humanity an enormous power to act upon nature, including its own biology. Other animal species have to play the health game with whatever cards nature deals them. Through the knowledge derived from culture, we humans can change the cards we have been given. This has been achieved through empirical observation of hard facts, the refinement of theoretical explanations of those facts, and the development of techniques and technologies to modify them. As a result we can ward off or heal infections and repair injuries in ways undreamed of two centuries ago. Doctors can replace blood, joints and organs, alter body chemistry, change the functioning of the brain, snatch infants from the jaws of death, prolong the natural life span and even artificially engender life itself. Put like this, biomedicine has acquired almost god-like powers, which with recent discoveries about the human genome can only increase astronomically in the future.

This, however, is where we start hitting ethical issues. Medical science has developed these amazing powers to modify nature. The question is – should it use them? Morality is a matter of values, and values in turn arouse people’s passions. It is precisely such value-laden passions that medical science frequently stirs up in its drive for dominion over biology. The answer to the question whether biomedicine should be allowed to use the power it has amassed may be an emphatic: ‘No!’ for some people. Indeed, scientific methodology itself, with its cool, clinical experiments and its tampering with the supernatural or natural order of things, is regarded in some circles as a violation of sacred values.
To adequately cover the collision between the power of biomedicine and the power of morality would require an entire section, indeed a whole book, in itself. Here, we only have space to note a few representative examples of the many ethical conundrums and controversies with which New Zealanders are currently wrestling. Each is easy to express, but virtually impossible to resolve.

**Embarrassment**
Perhaps the most common of all problems bedevilling interaction between the public and medical practitioners is the sense of shame or embarrassment associated with our ‘private parts’. Quite a lot of our interactions with doctors and nurses involves highly intimate and personal matters usually surrounded by taboos. We have to talk embarrassingly openly about our bodily functions, often floundering for the right vocabulary to employ – the technical one of penises, vaginas, faeces, urine etc, or the colloquial expressions with which we are more at ease, but are afraid may offend the doctor. Even more humiliated, we have to submit to having our genitals or anuses peered at by a stranger, or being assisted when urinating or defecating. We know such things have to be endured, but most of us don’t like it one little bit. We may even refrain from asking for medical assistance we badly need, through fear of the shame that may result.

**Stigma**
In principle, disease is morally neutral. People get sick; doctors treat them – end of story. This neutrality, however, gives way to moral condemnation, even on the part of some medical practitioners themselves, when the illness carries a stigma along with it – that is, a sense of disgrace. The most obvious example is HIV/AIDS. We are morally neutral, or actively sympathetic, if the victim is ‘innocent’, as when children are born with the condition. Sympathy often turns to opprobrium, however, if the sufferer is a male homosexual. In some quarters, gays are stigmatised on a number of fronts at once. Their sexual orientation in itself is regarded as simultaneously a violation of religious taboos and a perversion of nature. As well, it is assumed that the disease has been spread through rampant sexual promiscuity – itself a cause for moral condemnation. To cap it off, the general public frequently exaggerates the danger of catching the disease. Its carriers may thus be shunned not only out of moral aversion but irrational fear. HIV/AIDS is just the most prevalent contemporary example of a more general phenomenon: certain health conditions are associated in the popular imagination with moral deviance, an association which makes it difficult for sufferers to receive the medical treatment they require.

**Matters of Life and Death**
On many occasions, medical practitioners hold life and death in their hands. Viewed one way, these are just natural biological processes. Most people, however, do not see them that way. Decisions about who lives and who dies, about who makes the choice, and the philosophical principles on which it is made, almost invariably spark off passionate public debates, the intensity of which is compounded by the fact that totally irreconcilable principles are at state. The brevity of the following examples is no reflection of the depth and breadth of the controversies surrounding them.

- Abortion
Doctors have the ability to safely terminate pregnancies. Whether or not they should use this ability is a heatedly contested issue. Two opposed value systems clash head-on, one asserting the inviolable sanctity of human life from its conception, the other claiming women’s right to control their own reproductive processes.

- **Prolonging suffering**
  At the other end of the life span, doctors have the power to keep people alive who, without intensive medical intervention, would otherwise die. They feel bound to do this because of the oath they have sworn not to do harm to their patients. However, friends and relatives – and sometimes the patients themselves – may feel on some occasions it would be more humane and dignified to let the dying process run its natural course, rather than artificially prolonging it. At the limit, they may even feel it is legitimate for doctors to hasten death – that is, practise euthanasia – if the suffering involved is too intense. Euthanasia is against the law, but those espousing it believe the law itself to be heartless. The debate here concerns what is meant when we speak of the value attached to human life. Is being alive valuable in itself, no matter how wretched the quality of that life, or is it more humane to allow people death with dignity?

- **Compulsory treatment**
  Some adults are strongly opposed to biomedical treatment, either because it violates their religious beliefs (as with the refusal of Jehovah’s Witnesses to accept blood transfusions) or because it can be brutally invasive (as with conventional cancer therapies). Grown-ups may legally refuse treatment themselves, but are they justified in imposing their values on their children, thereby putting the latters’ lives at risk? New Zealand law allows the compulsory treatment of children in such cases, but the parents of one child with cancer took him into hiding from the police in 1999 to avoid such compulsion. Whose values should prevail – those of the biomedical establishment which claims to be protecting the life of the child, or those of the parents who say there are higher principles than physical life and death involved?

**Bodily integrity**
In many religious systems, it is believed there is an integral link between the body and the soul, which must be respected even after death. The body, therefore, must be intact on burial. This belief, for instance, is widely held by Māori. For biomedicine, on the other hand, dead bodies are just inert lumps of matter, whose bits and pieces can legitimately be used for a variety of secular purposes, such as forensic investigation, research or teaching. There has been considerable ill feeling in this country between those who regard the bodily integrity of the dead as sacred, and those for whom a corpse is just a corpse – a classic collision of sacred and secular paradigms.

**Genetic engineering**
Possibly the biggest ethical issues of all have only recently come over the horizon. Since the life sciences cracked the mystery of the human genome – the chemical blueprint that generates our form and functions – they have acquired the potential to engineer the basic building blocks of life itself. Biological engineers are developing the power to burrow into the body right down to its constitutive molecules and alter these at will. They can harvest brain stem cells and shape them to their own ends. They can also splice human and non-human genes, thus enabling cross-species
hybridisation. For scientific medicine, these discoveries open up therapeutic prospects that far exceed all previous advances in the art of healing. For those who believe in the sanctity of human life, they are an unspeakable abomination. There has probably never been a bigger standoff between religious and scientific worldviews than the one over genetic modification – and it is only just warming up.

At the start of this module, we represented medicine as an epic struggle between nature and culture, mediated by the various other spheres of the social map. We have now reached an appropriate place to draw our discussion to an end, since the possibilities opened up by genetic engineering close the circle. Until a couple of centuries or so ago, human beings, along with all other animals, were pretty much at the mercy of nature. All people could do in face of illness was invoke supernatural help, apply usually ineffective folk remedies, or put up with the barbaric ministrations of doctors, who had got the basics of human physiology wrong. Nature had things largely its own way. Today, scientific culture has refined itself to the point where it can penetrate to the hidden core of its natural adversary and modify the chemical infrastructure of life itself. There could be no more emphatic triumph of the power of culture over that of nature.

Here, however, we run into the ultimate ethical question: ‘Should it use that power?’. At this point, sociology perforce falls silent. Its job is to clarify issues. It cannot resolve them.
FURTHER READINGS

[Particularly recommended texts are marked *]}


Websites


