NHS Health Scotland

Power – a health and social justice issue

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Power – a health and social justice issue

Aim of the briefing

To outline the theory of power as a fundamental cause of health inequalities, and to generate discussion to inform NHS Health Scotland's programme of work to achieve a fairer, healthier Scotland.

Introduction

Power is regarded as one of the three fundamental determinants of health, together with income and wealth. These are the 'causes of the causes' that underpin inequalities in disease and life expectancy or, alternatively, create the potential for equity in health across the population.

NHS Health Scotland's *Inequalities briefing Health inequalities – what are they and how do we reduce them?*[1] outlines the fundamental causes of health inequalities as an unequal distribution of income, power and wealth rooted in political and social decisions and priorities.

'Power' is a complex and contested concept in terms of how it is expressed, by whom, where and in what ways, drawing on a range of sources and with a variety of effects. Power relationships can be visible and obvious, but are often hidden and covert.

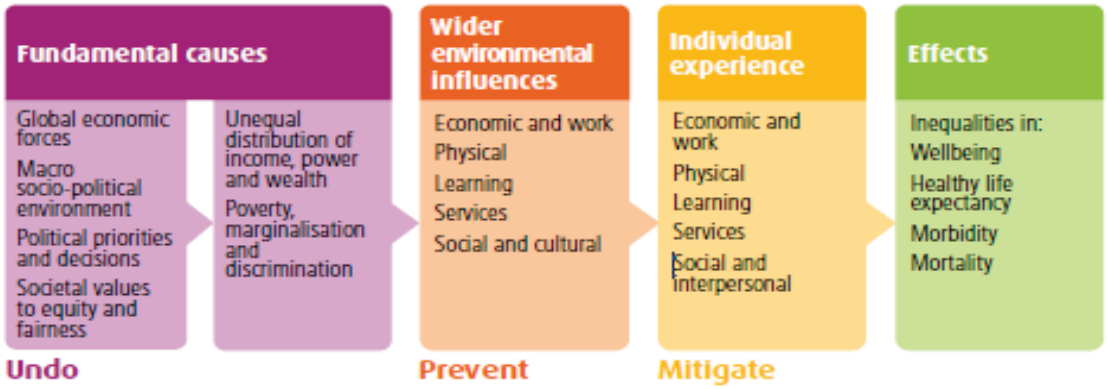
This paper summarises the main ways of thinking about types of power to help our understanding of what it is and its relevance for health inequalities. In exploring these issues the paper aims to generate discussion to inform NHS Health Scotland's work in tackling power inequalities.

Health inequalities

Health inequalities are the unfair and avoidable differences in people's health across social groups and between different population groups. To tackle health inequalities requires action that addresses the three fundamental drivers of social inequality: power, income and wealth. These drivers affect the distribution of wider environmental influences on health, such as the availability of good quality housing, work, education and learning opportunities, as well as access to services and social and cultural opportunities in an area and in society.

The wider environment in which people live and work then shapes their individual experiences of, for example, low income, poor housing, discrimination, and access to health services[2]. This has implications beyond inequalities in health. Less equal societies, in terms of differences in income across the population, show an association with doing less well on average over a range of health and social outcomes including levels of violence and homicide, teenage pregnancy, drug use and social mobility. Fundamental cause theory (figure 1) suggests similar inequalities in outcomes from an unequal distribution of power and wealth[1].

Figure 1: NHS Health Scotland's theory of causation[2]



While Scotland's health is improving, inequalities remain wide as the health of the least deprived groups has improved at a faster rate than the most deprived. These inequalities result in an avoidable burden of disease, hampering progress towards achieving a healthier population and a fairer society.

Why is power important as a health and social justice issue?

Everyone has the right to an adequate standard of living for health and wellbeing. The World Health Organization (WHO) reasons that protecting this right through fair access to goods and opportunities is the concern of political authorities and requires a standard of governance that enhances individuals' and communities' broader capacity to make decisions about how they wish to live[3].

Social inequalities shape the inequalities in health within populations. Fundamental cause theory suggests that inequalities in income, wealth and the distribution of power create the conditions under which the better-off in any society can take advantage of situations to a greater extent. In consequence, their health is persistently better, and health inequalities are replicated over time, even when the intermediate mechanisms and causes of death change. And so in shaping these conditions, access to these fundamental resources, as well as others such as knowledge and prestige, mediate this advantage. Inequalities in access to these resources are shaped by social, economic and political processes.

The WHO argues that achieving the right to health requires a redistribution of power, and an empowerment of deprived communities and marginalised groups, to allow people to exercise the greatest possible control over factors that determine their health. Understanding structural inequalities and power differentials therefore becomes critical to tackling health inequalities and achieving social justice.

What we know about power

We use the word 'power' daily in many contexts. Different ways of categorising and describing power carry different implications for understanding its relationship to health inequalities and the routes to address and redress power imbalances. Power is the ability to act in a particular way, as a capacity, strategy, shared resource or relation[9]. This is a complex concept which includes the ability or capacity to do (or not to do) something and to exercise influence, control or force, through a variety of means. Power arises from additional resources and beneficial connections. Having power is protective of health, no matter what mechanisms are relevant at any time[2, 4, 7].

The focus of this paper explores power as outlined in the fundamental cause theory above, defined in NHS Health Scotland's strategy[8], and informed by the WHO conceptual framework for action on social determinants of health[3].

The WHO framework summarises four different types of power:

- 'power over' whereby some are able to influence or coerce others
- 'power to' whereby individuals are broadly able to organise and change existing hierarchies
- 'power with' is the collective power of communities or organisations
- 'power within' is individual capacity to exercise power.

The WHO reflects that classic ways of looking at power are closely related to ideas of domination, coercion and oppression, understood as 'power over'. Such an exercise of power is not necessarily overt or involving physical violence or threat. Coercive power can be covert through dominant or advantaged groups shaping public debate or political decisions, or otherwise influencing the perceptions or options of more disadvantaged groups. As such power is routinely vested in major political, economic or cultural institutions it has been described as 'structural oppression'[3]. This explains how power operates to favour and privilege some groups over others, creating injustice and disadvantage. Structural oppression influences the life experiences and subsequent inequalities in health outcomes of those who are less advantaged.

The WHO framework[3] notes that theories highlighting both overt and covert forms of 'power over' and their dominance in social, economic and political processes demonstrate the obstacles experienced by groups in asserting their collective power. Challenging the dominance of those with 'power over' is necessary to begin to tackle power imbalances.

Approaches based on concepts of power to, with and within can suggest enabling actions to achieve greater equity in the distribution of power:

> ‘An approach based on “power over” emphasises greater participation of previously excluded groups within existing economic and political structures. In contrast, models based on “power to” and “power with”, emphasising new forms of collective action, push towards a transformation of existing structures and the creation of alternative modes of power-sharing…’[9]

The WHO therefore argues that action to tackle health inequalities must explicitly redress power imbalances to the benefit of disadvantaged groups. Given the multiple definitions of power, it is important to note that it can be understood as a fluid resource, rather than a limited one – some would argue that power is not a zero sum game (i.e. it is not a finite resource that needs to be taken away from others)[10, 11]. A broader understanding of the dimensions of power (the sources, positions, spaces and levels of power – see figure 2) and their interactions helps us to identify the different entry points to achieve change[10].

Figure 2: Power frameworks[10, 11]

	Definition
Sources of power	Where power comes from (e.g. capital, information, networks).
Positions of power	Who has power? This may change according to context and setting.
Spaces and levels of power	Where power is exercised.

Changes in power relationships can take place at various levels – from the individual, the community, in workplaces, in the market for goods and services, and within social, economic and political institutions – and these need to happen in tandem to reduce health inequalities. It follows that micro-level changes will be insufficient without structural reform at the macro level. Action on the social determinants of health inequalities is therefore a political process that engages disadvantaged communities and the state[3].

Conclusion

Power is relational, which means that it does not belong to one person, but exists in the relationships between people and groups of people, sometimes organised (e.g. within corporations or unions) and sometimes not. It is also context specific, in that people can have a lot of power in some situations but they can be powerless in others. These characteristics make it distinct from income and wealth as a fundamental cause of health inequalities.

The sources and positions of power, the expressions and forms of power, and the spaces and levels of power have implications for the causes and consequences of health inequalities in Scotland. Power is both a barrier and an opportunity to redress these inequalities. Indeed, the values and ambitions inherent in recasting power to tackle inequalities are already accepted in core policy documents, albeit inherently, such as the Christie report and principles[12], and the Community Empowerment Act[13] as well as the Scottish Government's 2015–16 Programme for Government[14] on Strengthening Communities.

A strategy to address health inequalities in Scotland requires action across all sectors and across a wide range of public policy areas. This will include policymakers, service providers, community groups and employers. It is not just a health issue – the right to health is a social justice issue[2].

Further papers in this series will summarise how power affects health and will look at opportunities for practical action to redress and redistribute power.

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