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Society, Community and Marginalization: The Countermeasures and Health

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1. Introduction

I have been a doctor for 45 years now, and medicine has left its mark on me. Medicine is a science, but the application of medicine to people is an art. The reason is that people are individuals, and each is different - with his or her education, work, family, culture, thoughts, fears and hopes. The doctor has an obligation to be scientific and logical, but he learns that "life is larger than logic". You will observe this schizophrenic position in my lecture. - Experience has convinced me that there is a close and important relation between culture and health, but I struggle to make it rational, and I struggle even more to make practical and effective use of it.

The title of my lecture is not easy to understand - not even for me. I shall not explain what I intend to do, but there is a logical chain of reasoning. There is much to say about doctors, but they like order.

2. The Norwegian society

I start with some words about our society and its development. When I was young, the country was poor and badly shaken from the war, but we have seen an unbelievable progress. Today, Norway is rich. If you travel in the country, you will see tidy farms, well painted houses, fine gardens and healthy children. Health has improved, mortality has decreased, and life expectancy has increased. The health service is well organized and distributed, and it does in general a very fine job.

During most of these years we have been ruled by social democracy. Norwegians are passionate believers in individual and local freedom, and decentralization is the key word in politics. Possibly, this may explain why Norway decided not to join the European Community.

Thus, progress has been almost unbelievable, but, unfortunately, there are also serious faults and weaknesses - "progress in the wrong direction", some call it. Here, I present a list of some of these negative trends, without troubling you with statistical data.

A. Increased:

- * use of alcohol, narcotics and drugs
- * crime, violence and murder
- * suicide rates
- * divorce rates
- * abuse of children and women
- * unemployment and disability benefits
- * use of health and social services
- * expectations

B. Decreased:

- * solidarity and fellowship
- * subjective health and well-being
- * self reliance and self care
- * traditions and religion

These are serious worries, and I believe we share them with most industrialized countries. All of them have been unexpected. In fact, we believed that economic

growth would reduce all these problems. I label them unintended and highly dangerous side effects of the modern development, and as a doctor I am only too used to side effects - even death - caused by well intended medical treatment.

In 1977 the American social scientist Aaron Wildavsky analysed American health politics in an article with the title: "Doing better and feeling worse" (1). This expression fits the Norwegian population. Objectively, we are healthier, but subjectively we feel worse, especially with mental health problems and muscular-skeletal disorders. There has been a tremendous increase in the use of the health service. The number of doctors has increased four times since 1950, and they are all extremely busy. The general practitioners tell me that life problems are almost as common as medical problems. Thus, medicalization of everyday problems is common. It is fair to say that the level of expectation has become extremely high. People feel that there is - or ought to be - a pill for every ill. It is the duty of the health service to solve all of these problems, and the ever increasing waiting lists are the main issue in Norwegian health politics.

What about culture? There has been a large and consistent effort to invest in culture, but we are left with two questions:

- Are we satisfied with the cultural development?
- What can culture do to turn the negative trends and support the positive ones?

3. The 2/3-society

I must add one very important aspect to my description. Every human society is organized as a social hierarchy with social classes. The main difference between clas-

ses are education, work, income, housing and possibilities for an active and satisfying life. Our society - like all others - has always had classes, but Norwegians have traditionally disliked this fact and claimed that we are a homogeneous society. Class differences are probably larger in many other countries, but the unfortunate fact is that they have increased in Norway during the last 20-30 years.

Thus, we are caught in what is called the 2/3-society, which means that about 2/3 are doing better and better, and 1/3 are doing worse and worse. Some of the unfortunate 1/3 are chronically ill or disabled, some are unemployed, some are mothers living alone with small children, some are immigrants, and some are old. As a group they share these characteristics:

Less resources:	education, income, work, housing, freedom
More often:	poor health and function unfortunate life style low self image and self reliance weaker social network and support less possibilities for physical and cultural activity

This is the problem of social marginalization.

What are the causes of this segregation? Obviously, there are many causes: social selection, chronic disease and disability, unfortunate social circumstances in childhood or plain bad luck. Some of these causes can be corrected, but rarely by the health service.

We know a good deal about the conse-

quences of social marginalization. A serious one is poor health. Research and statistics over 100 years tell us that the increased morbidity and mortality is not due to specific diseases, but to a generally increased susceptibility and decreased resistance to disease. This is probably related to social stress at the bottom of society with little individual freedom and no hope of improvement (2). Very similar findings have been made in animals which live in social hierarchies (3).

I will illustrate these problems with a few statistical "shots" from different countries:

- The first is from England: Mortality for men in 1981 of class I (professional) was 0.66 and of class V (unskilled) was 1.66 in relation to the national average. Class V lost 7 years as compared to class I (4).
- The second is from USA: The differences between the lower and the upper social class in morbidity, disability and dependency increased markedly over life (5).
- The third is from Canada: Life expectancy was considerably longer for the upper class, and yet the upper class had fewer years of final disability (6).
- The last two are from Norway: Mortality in the deprived parts of Oslo in 1990-93 was almost twice as high as in the richer parts (7). Furthermore, several measures of health show that the percentage in poor health is twice as high among people with only basic education as compared to people with university education (8).

My conclusion is that our most important problem in public health is the health and well-being of the unfortunate minority.

The fortunate majority can and do fight for themselves and therefore need less public attention.

4. The concept of health

At this stage I must discuss the concept of health and look for possible relations between culture and health.

WHO has formed a glorious concept of health:

"Health is not only freedom from disease, but complete physical, mental and social well-being"

This definition is well-intended, but a Utopian idea and it does not fit the facts of life. For the last 20 years I have been a doctor to very old people. Again and again they tell me that they have had serious diseases - tuberculosis, poliomyelitis, arthritis, cancer etc., but nevertheless they insist that they have been satisfied with their health. This experience was confirmed in a large Norwegian survey where 36% of the population answered yes to two apparently opposite questions. They said: "Yes, I have a chronic health problem", and they also said: "Yes, I am satisfied with my health". Thus, many people do not fulfil the WHO-definition, but nevertheless claim to be healthy. My definition of health is therefore different:

"Health is the ability and capacity to cope with and adapt to the inevitable difficulties in life - disease, disability, accidents, life problems, conflicts and old age"

I have tried to develop this definition into a general model of health - Figure 1.

The vertical scale starts in the negative -

disease - at the bottom. It passes through zero - no disease, and ends in the positive - health. Obviously, this idea is illogical, because there is no continuum from disease to health. In fact, the zero-line marks a qualitative shift. Below zero are diseases, disabilities and risk factors - the domain of medicine and the curative health service. Above zero are positive resources, salutary factors, strength, friends, family and happiness - the domain of a positive life. I believe the logical weakness of the continuous scale is the strength of the model, because it forces us to look at people as entities - complete with negative and positive factors. It may also serve to illustrate the situation of health in spite of disease - a concept which is in agreement with people's experience, but in conflict with the WHO's definition of health.

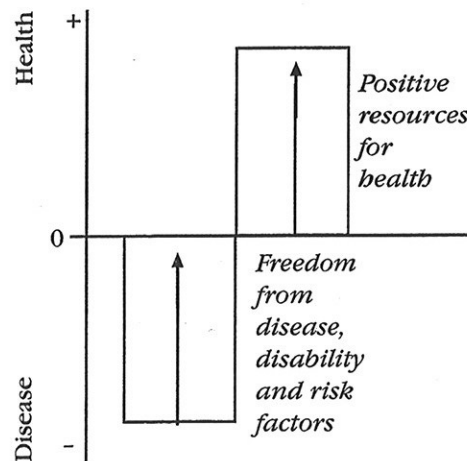


Fig.1 The concept of health

It is important to analyse the positive factors of health. My source for this analysis is innumerable conversations with very old patients over many years. Here are the most important salutary factors, as they - and I - see them:

- Personal characteristics - to have hope and optimism, a positive view of oneself and a natural confidence
- Well being and security: to have positive experience and confidence, and ability to cope with life
- Social network and support from family, friends and neighbours: to know that one is not let down
- A positive local environment: to feel acceptance and closeness, to give and receive support
- A cultural fellowship: to know one's roots and values, to belong in a culture

These impressions are supported by many scientific studies, f.ex. by the study of Jewish survivors from the concentration camps by Aaron Antonovsky. His conclusion is the concept of "sense of coherence", which has three parts: comprehensibility, manageability and meaningfulness (9). This means that you must be able to understand and manage life and also to find a meaning in it.

The simple conclusion is this: the more you have of positive resources above zero in the model, the better you can cope with problems below zero. If there are few or no resources and no hope of improvement, this increases susceptibility to disease and decreases resistance. There are strong reasons to believe that a life at the bottom of society in itself produces social stress and chronic disease (2).

5. Health and culture - prevention of disease and promotion of health

I now turn to health and culture, and I start

with the role of culture in the prevention of disease and in the promotion of health. To me, this is the most important role.

In the model, culture can be effective both below and above the zero line. Below the zero line it has been well documented that physical exercise and sports - which are an important part of culture - can prevent and postpone heart disease, stroke and diabetes. It is also very likely, but less well documented, that cultural activities which provide positive social activities and companionship - like all kinds of group activities - protect people against heart disease. We know that social stress and aggression, and probably also social isolation, are negative factors in the development of heart disease, high blood pressure and stroke.

Another cultural factor should also be very seriously considered below the zero line. Violence, crime, alcohol and narcotics are extremely serious problems, and also fill the mass media. Is it time to discuss - and possibly investigate - whether we are satisfied with the mass media in our culture? As a doctor I think the time is long overdue.

However, it is even more important that culture has a job to do above the zero line. It can promote health and wellbeing, thereby improving people's ability to cope with life, disease and disability. These effects are more difficult to study scientifically, but I believe they are very important, especially for children and young people. This - to me - gives strong support to the voluntary organizations, whether they deal with sports, music or scouting. There are perhaps three obvious conditions for these positive effects:

- Active participation. It is not good enough to be a spectator, you must take active part in the activity
- The activity must be inclusive, not exclusive
- It must have a strong and positive social effect

It is difficult to fulfil these conditions, and I come back to them towards the end.

6. Health and culture - in the health service

The second aspect of health and culture is to promote a culture in the health service. This aspect has received much attention, for ex. through "Arts in hospital".

Obviously, the hospital buildings should have a high cultural standard to provide a therapeutic environment. This aspiration has received much support in this country. In general, Norwegian hospitals are clean and nice, and arts have received both money and interest, f.ex. in the new regional hospital in Tromsø. This is very commendable, but there is one important limitation. The staying time has become so short - five or six days - and both patients and personnel are so extremely busy that the positive effects probably are quite small.

However, in the long term institutions for rehabilitation and care - like the nursing homes for the old - the culture aspect is very important, and much more could and should be done.

I should like to mention one field where probably much more could be done, and that is music. There is a story about that by the English doctor and writer, Oliver Sacks. He was brought to a hospital in Lon-

don after a serious injury in the Norwegian mountains. He stayed in a little room without windows and gradually lost hope for both life and limb until a friend brought him a band with Mendelson's violin concerto. He played it over and over, and gradually he recovered - first his hope and then his health (10). I think that the health service should work much more systematically with music, f.ex. for Parkinson patients.

My conclusion is that this is an important and promising field, but it requires more systematic work and critical evaluation.

7. Culture for health

The third aspect of health and culture I call culture for health. In the old days, when I was a young doctor, there was a definite culture for health. It had three important elements:

- The first was to be tough. Disease was part of life and should be borne with patience and dignity
- The second was to look after yourself and trust your family and friends
- The third was to wait before you turned to the doctor. When you finally went, there could be two results. Either the doctor said that you were seriously ill and needed treatment, or he said that nothing was wrong and sent you home. The last result was the worst, because you had lost face.

Today we have an entirely different culture, almost the opposite - as I explained above. The health service and the doctors have contributed to this development, f.ex. by creating a constant fear of cancer.

It is an important task to restore a reasonable culture for health. People should realize that they can and should do a lot for their own health and that it is important to avoid medicalization of their everyday life. Medicine has very definite limits and potential serious side effects. People should also realize that death is part of life. This means that we need a new programme - beginning both in schools and in medical schools - to re-educate people and to create a new and better culture for health. This is a formidable pedagogic challenge.

8. What can we do?

Towards the end I come to practical considerations. As you know, doctors have an imperative to do something - right or wrong.

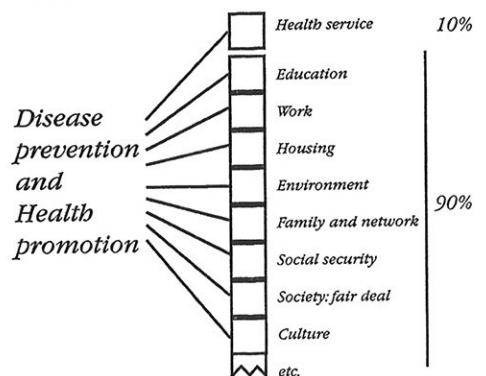


Fig.2 Health is more than health service! (Adapted from 1).

First, I emphasize that health and culture have two things in common. I mentioned Wildavsky, and he also coined the so-called 10-90 rule for health (1).

This rule says that the health service can only contribute 10% to people's health. The

rest must come from all the other fields and sectors of society - work, education, housing etc. I believe the same is true for culture - only 10% comes from professionals in what you may call "the cultural service". The rest must come from all the other sectors in society. This has important implications:

- First, health and culture both depend on the kind of society we create for people, and the 2/3-society is bad - both for health and culture. It is not possible to use the health service or the culture services to make up for serious and increasing inequity. Some 150 years ago, a famous German professor of medicine, Rudolph Virchow, said that health is politics. The same is true for culture.

- Secondly, both health and culture depend on cooperation across professional and other barriers.

- Thirdly, health and culture depend on participation. The goal is not health - or culture - for 2/3, but for all.

This is all very well, but can it be put to practical use? This is obviously extremely difficult, but it is the challenge we must face. Here are my reflections:

1. The young is the most important group to work with and for. It is hard for me to say that, because I have such a large personal investment in the services for the elderly. But the elderly have effective spokesmen and lots of attention - the young have not. Furthermore, the elderly are the past, and the young are the future of the nation.

2. We must concentrate on the unfortunate minority. The fortunate majority can look after their health and culture themselves.

3. The first step is education. If we fail to provide first-rate primary and secondary education for the minority groups, everything else will fail.

4. It is important to increase participation and access. One way of doing this is to increase the support for the voluntary organizations, and we should encourage them to include the unfortunate minority - not only sports for the handicapped, but also culture.

5. We should work actively to improve what I called a culture for health. This requires an active dialogue with the health profession and the population.

9. CONCLUSIONS

In this lecture I have tried to work my way through the difficult, but important relations between health and culture. My emphasis has been on social differences and marginalizations, and my message is clear: unless we build our society on the principle of solidarity and the idea of health and culture for all, we shall not succeed neither in health, nor in culture.

To illustrate my message, I go back in history to Norway 1910. Tuberculosis was a dreadful problem, causing 20% of the deaths, and there was no effective therapy. Three principles proved to be decisive:

- Improve the life situation for the population, especially for the poor

- Emphasis on prevention and promotion of health

- A caring society, including a national voluntary organization with 1500 local chapters which developed a culture for help and support.

My first job in 1950 was in a small rural community. It had a nursing home for 55 young patients with tuberculosis. These patients were included in the society - not abandoned. To me, this was a lesson in solidarity for life. This, I think, is what health and culture is about - solidarity.

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