When Religion and Health Align

Mobilising Religious Health Assets for Transformation

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and Teresa Cutts (editors)

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INTRODUCTION

Equal access for equal need is a commonly accepted equity goal for health systems. It serves as a beacon for health system development and reform actions that seek to reduce existing inequities in service provision. Such inequities are commonly taken to be demonstrated by differential patterns of health care use between population groups categorised by markers such as socio-economic status, race, ethnicity or gender. Such differences are judged inequitable, that is unfair or unjust, because the identified population markers do not biologically pre-dispose population groups to illness. Instead, they are markers of unfairness in the way in which society chooses to allocate resources and power between population groups, choices that generate unnecessary, unfair and avoidable, and hence inequitable, patterns of utilisation.

This paper, first, elaborates the notion of access and considers the relevance to debates about health system access of ‘healthworlds’ (Germond & Cochrane 2010), a concept coined by researchers in the African Religious Health Assets Programme (ARHAP). Second, it considers the relevance of trustworthiness to debates about access, noting that trust is also embedded in healthworlds. Third, based on these concepts it draws out some implications about how to strengthen health care access.

The perspective here is of a health policy and systems researcher, someone concerned with ‘how societies plan, manage and finance health services as well as [with] investigation of the role and interests of different actors in the health system’ (HPSR n.d.). Such research often adopts a macro-perspective, looking from above or outside the system, to consider how best to re-engineer it to better meet system goals. In contrast, this paper is located within a small but growing body of work that seeks to understand the health system as an array of relationships among different actors that are themselves influenced by a wide range of social, political, economic and cultural factors. In understanding such relationships, as Long (2001:91) has noted more generally, ‘it is
essential to avoid framing problems and looking for solutions from within a framework of formal-logical models and rationalistic procedures .... [Instead] research practitioners must devise ways of entering the everyday lifeworlds of [implementation] actors (frontline personnel and locals) to learn how these latter deal with the complexities of implementer-client relationships’.

**UNDERSTANDING ACCESS AND ADDRESSING ACCESS BARRIERS**

Although widely used in health policy debates, approaches to understanding and evaluating access remain elusive. Indeed, although utilisation is often presented as a measure of access, the two notions are generally understood as distinct from each other. Aday & Andersen (1975), for example, distinguish between ‘having access’, denoting the potential to use a service if required, and ‘gaining access’, meaning initiation into the process of using a service. More recently, Thiede (2005: 1453) has defined access as ‘a precondition to health services utilisation where such services are needed. Access is best defined as “freedom to use”.’ This definition combines the understanding that access reflects a set of conditions that allow for the appropriate use of health services, including empowering individuals and communities to choose if and when to use health services (Thiede et al. 2007). Access cannot, therefore, be imposed on patients: it depends on them having the freedom to decide whether or not to use health services.

These definitional debates point to the interface between patient and health system that is embedded in the notion of access. Indeed, access is generally understood as reflecting the ‘degree of fit’ (Pechansky & Thomas 1981) between the health system and its clients, as a relational notion involving two-way interactions between client and health system across a range of dimensions (Thiede et al. 2007). These dimensions, variously categorised in the health systems literature, essentially combine concern for physical or geographical access (availability), financial access (affordability), and socio-cultural access (acceptability) (Thiede et al. 2007).

Although the notion of comprehensive primary health care as defined at Alma Ata in 1978 recognised all these dimensions, the practice of health system development in low and middle income countries has primarily focussed on availability and, more recently, affordability, and has given primary emphasis to actions within the health system. Thus, extending service availability by constructing facilities within a certain distance of the population, offering outreach services in the communities surrounding a fixed facility, ensuring drug availability at point of use, or introducing protocols to guide health worker performance and improve quality of care—see the Integrated Management of Childhood Illness approach (IMCI n.d.), for example—are all examples of actions tackling availability problems. Much less attention has been paid until recently to
affordability barriers, but current demands for the removal of health care user fees and the implementation of health care financing mechanisms, such as forms of insurance that allow the risk of ill-health and the associated costs to be shared among populations, reflect this concern.

Some types of health system interventions do, however, recognise the need to work simultaneously at both the system and client levels. Directly Observed Therapy for TB care, for example, addresses access barriers through a focus on wider health system improvements and better provider practice, as well as actions to support patient adherence and improve access to care (http://www.who.int/tb/dots/en/). Meanwhile, ‘demand-side financing mechanisms’, such as conditional grants issued to those who use certain health services at pre-specified intervals, seek to address the affordability barrier to accessing services at the same time as incentivising their use.

From an access perspective, however, a strong criticism of these approaches focuses on their use of structural interventions to enforce changes in patient behaviour, as it compromises the patient’s freedom to choose—an inherent element of current understandings of access. In addition, as with most health sector reform prescriptions worldwide, there is an assumption that health system planners can alter the behaviours of health system actors simply by re-configuring the hardware elements of the system—the organisational, financing and legal structures that represent the exterior of the system. However, this denies the reality that all actors, including patients, have some power to influence the health system and its functioning, and may choose to ignore or subvert interventions or changes imposed on them (Blaauw et al. 2003; Mackintosh 2001). The agency of health system actors, their relationships with other actors, and the values, beliefs and norms underpinning those relationships, represent the interior of the health system, its software if you like, and this has generally been ignored in recent international debates about health systems (Blaauw et al. 2003; Scott et al. 2003).

Indeed, the access dimension of acceptability, which by definition requires particular consideration of patients’ perspectives and views, has so far been given very little attention in Low and/or Middle Income Countries (LMIC) health policy debates. Thiede et al. (2007:110), for example, define acceptability as ‘the nature of service provision and how this is perceived by individuals and communities’. They note that this encompasses the degree of fit between providers and individual patients as well as between health services and the socio-cultural setting in which they are being delivered. Thus, drawing on the wider health-seeking behaviour literature and frameworks, acceptability can be seen as the social and cultural distance between health care systems and their users (Hausmann-Muela et al. 2003). These definitions clearly point to the importance of moving beyond a focus on individual patient behaviour in understanding access, to considering the broader community level and
socio-cultural influences over patient behaviour. MacKian (2003:19), for example, notes that ‘health seeking behaviour studies which are either facility or household based miss the opportunity of capturing the wider community picture, which could be all important in understanding why, when and how people use health system facilities.’

**Unpacking Acceptability**

In seeking better to understand the acceptability dimension of access, I have previously drawn on empirical evidence about health seeking behaviour to identify three facets of acceptability (Table 1).

*Table 1: Acceptability facets*

<table>
<thead>
<tr>
<th>Acceptability facet</th>
<th>Empirical evidence shows that health seeking behaviour is influenced by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The fit between lay and professional health beliefs</td>
<td>• perceived effectiveness of treatment provided and possibility of cure (and perceived importance of drugs to effective care)</td>
</tr>
</tbody>
</table>
| Patient-provider engagement and dialogue | • patient ability to exercise voice in medical care encounters  
  • provider behaviours and attitudes towards patients and, in particular, communication practices and maintenance of confidentiality  
  • provider stereotyping of and discrimination towards groups of patients |
| The influence of health care organisational arrangements on patient responses to services | • fit between health service structure and routine practices of intended beneficiaries |

*Source: Gilson 2007*

All three facets provide, first, indications of the ways in which acceptability issues may themselves mediate the degree of fit between patients and the health system around availability or affordability. Ensuring access to services perceived to be of good quality is, thus, not only a function of action within the health system, as particularly
stressed by the availability dimension (Thiede et al. 2007). It also requires consideration of patient beliefs about health and healing and, hence, what types of services communities deem efficacious. Affordability, meanwhile, may be influenced by the ways in which the formal scale of charges and exemptions applied in any facility are communicated to patients. Where clerks or administrative staff take little care in their communication of these procedures and, indeed, abuse their power over patients, this can result in misunderstandings that only raise affordability barriers—such as when patients do not ask for an exemption because they simply do not know they are eligible, or they are afraid of being stigmatised by asking for one (Gilson et al. 1995: 387).

Second, all three facets point to the influence of a wider set of factors over patient behaviour. As I have argued elsewhere (Gilson 2007: 133–4), these include the advice of family members and neighbours over where to go for care, itself influenced by beliefs about illness and healing, rumours and reputation about particular providers, popular discourse about the state, and the power relations between health system/providers and patients.

Third, each facet is also shaped by the wider influences over the health system’s approach to patients and provider behaviour. Providers are, for example, influenced by organisational factors such as workload pressures, job demands and levels of peer support. In addition, the wider organisational culture of the health system can encourage providers to adopt authoritarian attitudes towards patients as well as limiting their ability to respond to their judgements of patient need. Indeed, the bio-medical and bureaucratic rationale of health services may shape providers’ practices towards patients in ways that alienate patients from these services, given their different understandings of health and healing (Gilson 2007:135).

Together, problems with these acceptability facets may lead patients to the decision not to seek care from particular health care providers; or to delay seeking care until illness severity has progressed. In cases where care is sought, they lead to misunderstanding or contestation about the nature of treatment and the need for adherence, and even to the denial of patient dignity during engagement with the health system. And such experiences are likely to be borne to a greater extent by poorer or marginalised social groups (Gilson 2007: 130).

What insights does the notion of healthworlds offer for access and acceptability? There remains too little recognition in health system debates that health is a cultural concept, generating not only different responses in different contexts but also a diversity of responses in multicultural contexts (Mooney 2007; Thiede 2005; NHMRC 2005). Yet greater acceptability of health services requires greater understanding of the diversity of beliefs about health and healing. The notion of healthworld recently introduced by Germond & Cochrane (2010: 308) encompasses and encourages such understanding, as it ‘acts as
a significant description of the empirical complexity of health beliefs and behaviours’, and so provides insights into people’s beliefs and experiences. Drawing from Habermas’s notion of the lifeworld as ‘the taken-for-granted background of our everyday life’, they describe the healthworld as that region of the lifeworld that ‘aims at comprehensive well-being’ (Germond & Cochrane 2010: 310, 314). This encompasses a consideration of physical, mental and spiritual health, across both individuals and groups (the family, the nation), rather than just the absence of disease at individual level.

Importantly, therefore, the idea of the healthworld provides a way of understanding how culturally embedded notions of health drive health-seeking behaviour by shaping the norms, values and attitudes of individuals. It helps explain, for example, why a range of health providers, including traditional healers, are commonly approached in the search for healing in African communities, and why the mix of providers used differs between diseases in response to the health seeker’s understanding of their causes (e.g. Goudge et al., 2009; Hausmann-Muela et al. 2003).

In addition, it highlights the strong potential for conflict between health seekers’ understandings of health and healing, their healthworld, and the rationality embedded in the bureaucratic/bio-medical structures and processes of health systems which, in Habermasian terms, are part of the entirely separate, systemic spheres of the state or the market that govern much of our lives (Germond & Cochrane 2010: 312). This conflict represents a critical access barrier, as it reflects a misfit between lay and professional health beliefs and is likely to underpin patient-provider encounters that disempower patients: ‘The healthworld norms and values of a patient may appear counter-factual to a doctor working within the biomedical scientific paradigm, undermining treatment, whilst a patient’s non-adherence to regimes of treatment can be understood in terms of healthworld contestations with the instrumental logic of biomedical science’ (Germond & Cochrane 2010: 315).

In these ways, the healthworld notion emphasises the relational nature of health and health care, depending upon ‘communication between agents in a relationship’ (Germond & Cochrane 2010: 317), in contrast to the individualistic and reductionist perspective of biomedicine.

Finally, by providing an opportunity to understand lay beliefs about health and healing, the authors argue that the notion removes the need to see such beliefs as an obstacle to be overcome—as is common in much health system debate. Instead, it provides a basis for the mutual understanding that is necessary for coordinated action between provider and patient: ‘A crisis or dysfunction in health ... generally requires an appreciation of subject’s cultural and linguistic constructions of illness and wellness, via communicative action, that is, with the goal of reaching mutual understanding and coordinated action’ (Germond & Cochrane 2010: 320).
But what are the forms of communicative action that allow such understanding and action?

**BRIDGING THE WORLDS OF PATIENTS AND PROVIDERS: WHAT ROLE FOR TRUST?**

The notion of trust is relevant to debates about health system access in part because it too is a relational notion. It focuses attention both on the nature of a relationship between two people, such as patient and provider, and on the relationship a person has with an organisation or institution, such as a health system. Moreover, it is developed through social interaction (Gilson 2003).

Trust generally involves the belief that another/others will behave in ways that are beneficial, or at least not harmful, to us. At the individual level, a patient’s trust in her provider is founded on the belief that the provider will act in her best interests (Hall et al. 2001:616). Trusting relationships, thus, provide the basis for coordinated action among individuals known to each other, and even among those not known to each other—such as between patients and the groups of people working within health systems (Gilson 2003). Giddens (1991) also distinguishes between the macro-trust relations between society and societal values and a health system, and the micro-level, inter-personal trust relations between, for example, patient and provider. But he notes that they are interconnected and reinforce each other. Intertwined macro and micro relationships are, similarly, reflected in the healthworld notion.

Patient trust of providers and health systems is also of direct relevance in understanding acceptability. It is itself commonly identified as an influence over health seeking behaviour (Gilson 2007), and the main factors influencing such trust directly reflect the three aspects of acceptability already identified (see Table 2).

Importantly, trust and power are two sides of the same coin in a relationship. Thus, whilst trust may provide the basis for the exercise of legitimate power, trusting too much, without caution, may lead to the abuse of power—including inducing or coercing trust (Gilson 2007). These different types of trust have been highlighted through close examination of interviews with patients, their interpreters and providers in a multi-cultural setting in the United Kingdom. From such examination, Robb & Greenhalgh (2007) have developed a taxonomy of trust based both on the ways in which power is exercised in the relationship, and the forms of interaction observed in the relationship, also pointing to the preconditions for each type of interaction (Table 3).

Hegemonic and involuntary trust are both predominantly based on the exercise of power, and involve the use of strategic interactions by the patient. Hegemonic trust reflects the power of macro structures that leads to unquestioning subservience to the system. Patients do what doctors tell them because they feel they should, simply, obey the
doctor. Involuntary trust, meanwhile, is a coerced form of trust based in the unequal power relationship between health care providers and patients. Patients do not automatically believe what doctors tell them, but have little power to question or engage doctors on equal terms and so have to resort to negotiation and manipulation to get what they want from the engagement.

Neither of these forms of trust provides a strong basis for the mutual understanding that is necessary to build the good fit between provider/health system and patient that underpins access. Indeed, they are more likely to lead to behaviours the health system would regard as malfunctions—such as the failure to attend follow-up appointments or to comply with treatment prescribed. They are also close to the borderline

<table>
<thead>
<tr>
<th>Acceptability facet</th>
<th>Patient trust is influenced by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The fit between lay and professional health beliefs</td>
<td>• perceived technical competence of providers, availability of drugs and necessary equipment</td>
</tr>
<tr>
<td>Patient-provider engagement and dialogue</td>
<td>• patients’ own characteristics and attitudes</td>
</tr>
<tr>
<td></td>
<td>• levels of provider respect &amp; compassion towards patients demonstrated in attitudes and communication practices, including maintenance of confidentiality</td>
</tr>
<tr>
<td></td>
<td>• lack of bias or discriminatory attitudes towards patient groups</td>
</tr>
<tr>
<td>The influence of health care organisational arrangements on patient responses to services</td>
<td>• range of services provided or accessible through provider</td>
</tr>
<tr>
<td></td>
<td>• concern that providers face incentives to pursue profit, not patient need</td>
</tr>
<tr>
<td></td>
<td>• continuity of relationship, and time spent, with provider</td>
</tr>
<tr>
<td></td>
<td>• institutional guarantees e.g. scrutiny mechanisms, training, ethical commitments</td>
</tr>
</tbody>
</table>

Source: Gilson 2007
Table 3: Types of health system trust

<table>
<thead>
<tr>
<th>Type of Trust</th>
<th>Voluntary</th>
<th>Involuntary</th>
<th>Hegemonic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interpersonal:</td>
<td>Empathetic, familiar, informal, 'as with a family member', linked to the</td>
<td>Forced dependency (effectively have no choice): contingent on, and constrained by, power relations at either interpersonal or institutional level</td>
<td>Shaped by system meta-discourses; not noticed or questioned</td>
</tr>
<tr>
<td>Institutional:</td>
<td>Confidence in the system and the roles and protocols that it supports</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Predominant Type of Interaction</td>
<td>Communicative</td>
<td>Strategic (unconscious)</td>
<td>Strategic (unconscious)</td>
</tr>
<tr>
<td>Preconditions</td>
<td>Perceived 'kinship' links e.g. ethnicity, country of origin. Intersubjectivity, mutual respect, continuity of positive encounters.</td>
<td>Social trends and values. Qualifications, reputation. Institutional checks and balances e.g. quality standards, training, complaints procedure.</td>
<td>Unequal power balance. Awareness of strategic options, skills in negotiation, manipulation or influence.</td>
</tr>
<tr>
<td>Source: Robb &amp; Greenhalgh 2007</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

of, and so may allow, unethical practice. Finally, both seem to reflect the access barrier resulting from a conflict between the health seeker’s healthworld and the bureaucratic/biomedical rationality embedded within health system structures and processes.

In contrast, both forms of voluntary trust are based on communicative action: action that is ‘sincere, open and directed towards achieving understanding and consensus’ (Robb & Greenhalgh 2007:437). This includes open conversation between provider and patient aimed at mutual understanding, as well as the voluntary actions based on institutional signals such as external measures of quality and reliability, signifiers like doctors’ white coats, the sophistication of equipment,
and the presence of institutional control procedures like complaints mechanisms.

The pre-conditions identified in Table 3 signify the bases of these forms of trust. Forms of communicative action are, moreover, likely to be possible when both patients and providers accept and use the voice of medicine, or when both engage with the health seeker’s healthworld, generating more humane interactions and better patient-centred care (Scambler & Britten, 2001).

The importance of communication and of communicative action to voluntary trust is also more widely recognised. In previous work, for example, I have spoken of the importance of open processes of debate and engagement that allow people really to hear each other, in building trust (Gilson 2005). Thiede (2005:1458), meanwhile, specifically notes that ‘there is a two way relationship between communicative action and trust’ but that, normally, health systems work with instrumental and non-participatory messages based on the belief that the biomedical approach is ‘right’.

What are the Implications of these Insights for Improving Health Care Access?

The notions of acceptability, healthworlds and provider trustworthiness all emphasise the importance of developing health systems that seek to understand patients’ and communities’ beliefs and perspectives, and so empower them, rather than imposing the instrumental rationality of the health system on them.

Thus, they point, first, to the importance of adopting a more nuanced and socialised notion of access than is common in health system debates. Box 1, for example, presents an expanded definition of access developed within the Nepalese Safe Motherhood Programme.

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**Box 1: Access defined**

Access is enabled in an environment that encourages people to utilize health services, within any given social context. At its best, it is a dynamic, participatory process based on good practice. Access advantageously uses local knowledge, perceptions and values, relevant traditional practices, preferences and beliefs, to enhance knowledge and awareness. Access encourages self-consciousness, voice and agency especially amongst women. Access embraces institutional, financial and infrastructure factors, included but not limited to funding, transportation and education. Access relies upon good provider attitudes, trust, honesty, responsiveness, accountability, and quality service delivery both at established facilities and outreach programmes. Access engages socially marginalized and vulnerable communities, is inclusive and is empowering. (Aitken & Thomas 2004: 8)
Second, from a policy perspective, acknowledging this more textured notion of access allows consideration of how the health system can seek a better fit between itself and its clients. This will require it to reflect on its own organisation and practices, patients’ expectations and the factors influencing them. Communicative action requires much more than better provider messages. The health system as a whole must sustain communicative interaction by being open to patients’ worlds and empowering them in their worlds. Table 4, for example, outlines a range of specific actions prompted by thinking about ways to strengthen patient judgements of provider and system trustworthiness.

Table 4: Taking action on acceptability and trust barriers

<table>
<thead>
<tr>
<th>Actions for all groups</th>
<th>Specific actions to address the barriers faced by socially disadvantaged groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Provider training to improve communication skills</td>
<td>Develop client-centred approach to service provision:</td>
</tr>
<tr>
<td>• Develop client-centred approach to service provision:</td>
<td>• Employ members of these groups within the health care system</td>
</tr>
<tr>
<td>• Greater time for consultations and continuity of patient-provider contact</td>
<td>• Ensure availability of signage in different languages, and of interpreters</td>
</tr>
<tr>
<td>• Improved coordination of primary care and referral services</td>
<td>• Improve coordination of health care and wider social services</td>
</tr>
</tbody>
</table>

Address time and convenience costs:
• Provide mobile outreach services to, or patient transport for groups living in, remote areas
• Re-locate staff to rural, remote areas

Patient empowerment:
• Employ patient care advisors
• Peer support mechanisms

Underpinning actions:
• Build supportive organisational culture within health care systems
• Strengthen leadership and management, particularly human resource management, within health care systems
• Establish dedicated funding sources and/or new funding mechanisms
• Develop social empowerment and accountability mechanisms that develop shared citizen-system responsibility
• Take wider political action to enable and support change

Source: Gilson 2007
Practices based on a communicative interaction approach would, moreover, encompass a process with community members and various stakeholders that ‘generates common, consensus-driven knowledge based around the role and interpretation of health and health care’ (Thiede 2005:1458).

The need for coordinated actions across different levels of the health system is, finally, stressed by the ideas of the Australian National Health and Medical Research Council about how to strengthen the cultural competence of its health system (NHMRC 2005). This report highlights the need for joint action at individual, professional, organisational and system levels (Box 2) to strengthen the ‘capacity of the health system to improve health and wellbeing by integrating culture into the delivery of health services’ (NHMRC 2005:7).

<table>
<thead>
<tr>
<th>Box 2: Four Dimensions of Cultural Competency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Systemic</strong> — effective policies and procedures, mechanisms for monitoring and sufficient resources are fundamental to fostering culturally competent behaviour and practice at other levels. Policies support the active involvement of culturally diverse communities in matters concerning their health and environment.</td>
</tr>
<tr>
<td><strong>Organisational</strong> — the skills and resources required by client diversity are in place. A culture is created where cultural competency is valued as integral to core business and consequently supported and evaluated. Management is committed to a process of diversity management including cultural and linguistic diversity at all staffing levels.</td>
</tr>
<tr>
<td><strong>Professional</strong> — over-arching the other dimensions, at this level cultural competence is identified as an important component in education and professional development. It also results in specific professions developing cultural competence standards to guide the working lives of individuals.</td>
</tr>
<tr>
<td><strong>Individual</strong> — knowledge, attitudes and behaviours defining culturally competent behaviour are maximised and made more effective by existing within a supportive health organisation and wider health system. Individual health professionals feel supported to work with diverse communities to develop relevant, appropriate and sustainable health promotion programs.</td>
</tr>
</tbody>
</table>

(NHMRC 2005: 30)
TO CONCLUDE

The healthworld notion provides a basis for better understanding health seekers' beliefs about health and healing, and emphasises the importance of communicative action for the coordinated action between provider/health system and patient that is always required in tackling illness. In these ways it adds to our understanding, both of the factors influencing the acceptability dimension of health care access, and how to address them. The role of communicative action also provides a bridge to the literature on trust between providers and patients.

This literature, together with wider thinking on the cultural competence of health systems, allows consideration of the wide range of actions needed to develop health systems that sustain communicative action, that empower patients and communities rather than imposing biomedical and bureaucratic rationalities on them.

REFERENCES


Gilson, Lucy. 2003. ‘Trust and the Development of Health Care as a Social Institution.’ Social Science and Medicine 56(7): 1453-1468


