Lancet and University College London Commission on Culture and Health

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Claim: **The systematic neglect of culture in health is the single biggest barrier to advancing the highest attainable standard of health worldwide.**

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Summary

Perceptions of physical and psychological wellbeing vary dramatically across and within systems of value, as do individual experiences within diverse contexts and patterns of practice. Today, global forces, planned and unplanned migrations, and emerging disease vectors create new forms of experience that continuously transform how health and wellbeing are understood and negotiated. At the same time, familiar illnesses - both communicable and non-communicable - persist and impact on individual health and household, community, and state economies. Such forces shape medical knowledge and shape how medical knowledge is understood, how it comes to be valued, and how and when it is adopted.

Cultural systems of value are dynamic and always changing. They vary dramatically, producing novel needs to which established caregiving practices adjust slowly if at all. In contemporary clinical contexts, the tendency to homogenize human nature is paradoxically driven by both a lack of awareness of the diverse ways in which wellbeing is contextualized, and a laudable moral commitment to define human needs and obligations of caregivers in universal terms.

Ignoring culture not only can lead to a focus on biological wellness as the sole measure of health, but to failing to see how culture can become a key component in health promotion, especially where formal resources are limited or absent. Governments are quick to slash programmes that bear the word 'culture' because their own cultural prejudices have led them to assume that culture itself is neither universal nor constant. Under such conditions, behavioural variables that influence real biological outcomes are dismissed as merely socio-cultural rather than medical. Blame is projected onto the already disadvantaged when institutions claim to have discharged their public health obligations in the face of fiscal constraints, often shifting responsibility for poor outcomes onto unscientific 'cultural' practices.

Many blame poor clinical outcomes on factors that are perceived to be beyond the control of care providers. Others argue that all health-care provision must be made more culturally sensitive in order to restore and maintain health in patients and populations. And yet others declare comprehensively that multiculturalism has failed and should be abandoned, citing its divisive potential. Regardless of who is held to blame, failing to recognize the intersection of culture with other structural and contextual factors compounds poor health outcomes, increasing the financial, intellectual, and humanitarian costs of ignoring cultural diversity.

But the influence of socio-cultural values on health outcomes is stunning: within and across cultures; in culturally diverse settings; and even globally when priorities are driven by the cultures of specific institutions. While resorting to an evidence base— that is, to 'what is known'—can enhance best practices, attending only to what is known, rather than what is not known (and hence not understood), can also justify dismissing why difference matters. In all cultural settings—local, national, global, even biomedical--the need, therefore, to understand the relationship between

culture and health, and especially the cultural factors that influence why health enhancing behaviours are or are not embraced, is critical.

Given the financial fragility of so many systems of care around the globe, and the wastefulness of so much of health-care spending, it is no longer acceptable to draw a line in the sand between clinical care and the socio-cultural values that define our understanding of human wellbeing. Ideas about health vary widely across cultures and should not simply be defined by measures of clinical care and disease. Health may be defined in broad environmental terms, or in quite local and familial ones.

While economic differences are fundamental in determining what is feasible, socio-economic status produces its own cultures of security and insecurity that cross-cut nationality, ethnic background, gender, age, sexuality, religion, and political persuasion. Socio-economic status has itself produced new cultures defined by levels of social security and the limitations on choice that privilege some and disadvantage others. Financial equity is, therefore, a very large part of the cultural picture, but it is not the entire picture; the capacity to attend to adversity is conditioned by a sense of social security that is only in part financial. Trust and social stability are central to human motivation, and therefore foundational for managing illness and alleviating suffering.

This University College London Lancet Commission on Culture and Health seeks to review health practices as they relate to culture, identify and evaluate pressing issues, and recommend lines of research that will be required to address current problems and emerging needs. This it does through the examination of key overlapping domains of culture and health: cultural competency; health inequalities; communities of care; and human wellbeing.

1. Culture and Health

i. Introduction

On February 6, 2013 a crowd gathered outside of London's Queen Elizabeth II Conference Centre across from Westminster Abbey. They were there to hear the verdict in the Mid Staffordshire NHS Foundation Trust proceedings that investigated the causes of hundreds of preventable patient deaths in just one National Health Service hospital system in the West Midlands between 2005 and 2009.

On the day of the announcement of the commission's findings, aggrieved families, policymakers, and members of the press assembled to hear the results. They all wanted to know on whose shoulders the blame for this travesty could be placed. As the crowd listened, the commission's lead attorney, Robert Francis, announced that no specific group or person could be held accountable for such malpractice. The real villain was "culture": it was the fault of culture that these crimes of neglect had

occurred; the culture of the UK's National Health Service was responsible for these unnecessary deaths by neglect.

As one newspaper put it:

> The victims and their families were not happy. The culture of the NHS is not something that can apologise and try to atone. The culture of the NHS cannot be punished for its misdeeds. They wanted to see someone held to account. But the verdict was clear. "It was", Francis announced, "not possible to castigate: failings on the part of one or even a group of individuals". There was no point in looking for "scapegoats". The guilty party was the "culture of the NHS". It was the culture that had ignored "the priority that should have been given to the protection of patients". It was the culture that "too often did not consider properly the impact on patients of actions being taken".[1]

Today, in assessments of health and health care provision, blaming "culture" is not uncommon. The knock-on effects of acknowledging the relevance of culture, however defined, extend broadly. In this case, members of the Care Quality Commission (CQC), the group that oversees health quality nationally in the UK, were subsequently also charged with participating in a "'tick-box' culture", 'presiding over a "dysfunctional organization", with a "closed culture"[2]. "Culture", here, supersedes nurses and doctors, hospital boards, local and regional health regulators, health policymakers, local and national politicians, and even referring GPs as a source of blame. Indeed, responsibility for misbehaving is extended to the culture of the very commission established to regulate the impact of localized cultures and practices on health.

Culture, as this example demonstrates, cannot be merely equated with ethnicity or national allegiance. We all participate in locally-defined forms of behaviour that not only produce social cohesion, but that limit our ability to see the subjective nature of our values, our human-to-human responsibilities, and our assumptions about objective knowledge. In this context, the responsibilities of doctors and health systems, and the priorities of policymakers and researchers, are also collective behaviours based on social agreements and assumptions—i.e., on culture.

Such examples put front and centre the degree to which culture cannot be ignored by science-oriented clinicians, disease specialists, and policymakers--making clear the need to understand the impact of culture, however defined, on caring for one another in the 21st century. Understanding culture and what it means is crucial to improving health. This is why disciplines that once focused solely on the study 'other' societies, today, are central to our future health and wellbeing. So what, exactly, is "culture"?

ii. What is Culture?

The anthropologist, Robert Redfield, once offered an elegant definition of culture as "conventional understandings, manifest in act and artefact".[3] This definition is

useful because it focuses not only on shared understandings, but because it also refers to practices and artefacts that are based on those understandings and that encode conventional beliefs. Culture, then, does not equate solely with ethnic identity; nor does it merely refer to groups of people who share the same racial heritage.

Redfield's definition is also sufficient because it is agnostic. The culture concept does not imply that all members of a group share a given value; nor does it imply that local ideas can be readily translated across or even within groups that share languages, practices and overt expressions of belief. For example, we can say that a particular society has conventional knowledge about medicinal plants, but this does not imply that such knowledge is evenly distributed among all members of that society: local healers may hold certain knowledge, but the fruits of that knowledge are available to anyone who visits them for assistance.

Moreover, the effects of that knowledge may vary widely across encounters with those healers; and what that knowledge suggests may also vary amongst various healers themselves when, say, they question a diagnosis. The same applies, of course, to surgeons, nurses, dentists, and so on, whose practices and values vary broadly even in Western Europe and the United States: where Germans may define low blood pressure as much as an illness as a health benefit; North Americans may use antibiotics to excess; and the French may choose to spend government health funds on spas and homeopathy.[4]

Saying that culture is about shared conventional understanding does not, however, imply that the cultural dimensions of the behaviours of any group of people are always overtly understood from within. Members may regularly–and wrongly— assume that their own practices are universal rather than particular. Monotheists, for instance, may assume that "religion" is about a belief in God, whereas for many in the world, religion does not involve the belief in any single, omniscient being at all. That is what we mean by a social convention—something widely evidenced (even assumed universal), but not often consciously questioned or critically examined. Culture may be, and frequently is, encoded and not overtly expressed, but its effects can be ubiquitous, including in daily scientific practices. Not only hospitals, but universities, scientific laboratories, global health charities, and government agencies all have their cultures, though they may appear less obviously 'cultural' than the kinds of cultures anthropologists traditionally study. And because they are sometimes more covert, their unexamined affects may actually be greater *because* they assume themselves to be culture-free.

More than a century ago the sociologist, Émile Durkheim, separated empirical facts (what we see and evidence) from social facts (what we assume when our beliefs remain unchallenged). For Durkheim, the things we take for granted are foundational to our existence even if, or perhaps precisely because, we do not always recognize them as particular. They transcend, in other words, our capacity for self-criticism, yet exercise an on-going effect upon us that is inversely proportionate to our awareness of them.

Indeed, outside of global and culturally diverse contexts, groups of people rarely believe their moral perspectives to be relative; and their awareness of how much their values are cultural can only be known when those values diverge from, or are in conflict with, other values that they are disinclined to embrace. This general observation is not only directed at health practitioners and their clinical behaviours, but applies to all of us—including philosophers and anthropologists who spend their lives considering such issues.

Thus, the impact of culture may appear overt when a clinician attempts to care for someone from another society; but when we think of how culture affects behaviours in a hospital, we may be reticent to view such activities as cultural in nature. This lack of reflexivity is easily demonstrated. When we speak of, say, 'middle America', or a 'silent majority', we are referring to shared values and categories of thought that survive in a largely uncritical manner; the 'silent majority' is made up not of silent people, but of the beliefs, habits, life-ways, ideas, and values of a majority that may or may not feel the need to express them overtly. For this reason, cultural values may only become obvious when members of a culture are faced with practices and beliefs that vary significantly from their own. Here, culture is not merely those variable behaviours and practices a group understands itself to possess and articulate daily, but those that are dormant, assumed, and taken-for-granted.

To expose this unselfconscious dimension of culture, anthropologist Fredrik Barth once metaphorically called culture an empty vessel--that is, a concept defined at its peripheries where it is contested and challenged. [5] Culture, in this sense, is a dynamic concept—sometimes overtly expressed, sometimes not openly defined. For example, citizens may rally around national identity in times of conflict, while happily returning flags to their cupboards in times of peace. They may, likewise, believe in human equality while participating actively in hierarchies of prestige. Because of its often-assumed nature, culture as a distinct category of inquiry is critical to the experience of health and wellbeing as well as healthcare—indeed, we believe healthcare's greatest hurdle; for you cannot easily assess the limits of your own ignorance—how much, that is, you do not know, and how much you assume uncritically.

Though we commonly view culture as a set of practices and behaviours defined by customs, habits, language, and geography which groups of individuals share, the hardest thing to know in a relative and comparative sense is one's own culture. This is what anthropologists call the *anthropological paradox*: on the one hand we believe that it 'takes one to know one' while, on the other, we acknowledge that the hardest thing to know critically is one's own culture—that is, to critique objectively the subjective nature of one's own practices. [6,7]

Is it any wonder, then, that understanding culture poses the greatest challenge to health? We, the authors of the UCL-Lancet Commission on Culture and Health, believe it is time to revise common views of culture as overtly shared, largely unscientific, ideas and practices. Culture can as much concern what we take for

granted and do not critique—what we assume is universal—as what we understand at the level of social diversity.

This taken-for-granted dimension of culture is clearly seen in our initial National Health Service example, and is critical in coming to grips with the major claim of this Commission: that the systematic neglect of culture in health and healthcare is the single biggest barrier to advancing the highest standard of health worldwide. While we accept, along with the Francis Commission, the accountability of culture for clinical malpractice, we more widely also suggest that examining culture holds the primary key to better practice. Not only are the things we find most difficult to examine those things we take for granted; when a society's own objectivity is compromised by local practices and covert understandings, we begin to see why 'culture' matters in ways that affect us all.

iii. Why Culture Matters

In 1952 the French anthropologist, Claude Lévi-Strauss, lead a study commissioned by the United Nations' Educational, Scientific, and Cultural Organization (UNESCO) to address the problem of racism and the threat it posed to world peace and stability.[8] In the period following WW II, a time when colonial values were still common, the project became an attack on ethnocentrism and its assumptions about the relative superiority of one society over another. In the short book, Lévi-Strauss "warns against genetic determinism; reveals the fallacies of ethnocentrism and facile cultural evolutionism; defends the rights of small societies to cultural survival; and revels in the intricacies of the symbolic systems of societies to the vast majority of his readers".[9] The imbedding of these concerns in a key UNESCO document by a leading anthropologist assured that the idea of culture--defined across the diverse ways we create social meaning—would inform contemporary views of multiculturalism, cultural competency, and the value of social diversity. UNESCO's perspective on cultural rights also, in other words, became foundational for how we now define health rights multi-culturally.

But the task of defending local ways of seeing, and especially of appreciating how culture influences local ideas about health and related health outcomes, is not always easy. Since that time, UNESCO has struggled to mediate between the need for universal human equality and the right to harbour diverse worldviews; and it has been criticized for its perceived ambivalence. Indeed, its policies (embodied in its 1995 report, *Our Creative Diversity*) if anything reignited the right-to-culture debate by promoting "a relativistic view of development and a universalist view of ethics". [9,10,11] In short, the problem with trying to respect local difference while promoting health universalism is that under such conditions culture can be used "to legitimize not just exclusiveness, but exclusion as well".[9] Apartheid, for instance, is an intolerable form of multiculturalism—separate but unjust, rather than separate and just.[12]

While Lévi-Strauss produced a document that became a baseline for decision-making about culture, it was impossible to foresee the ways in which UNESCO's concerns

might contribute to the ossification and stereotyping of indigenous peoples. There was simply no way of knowing at that time how indigenous rights issues would come to be legally tied to court cases involving the return of indigenous property;[13] nor of knowing how those definitions of culture would encourage the racial use of biological markers to determine indigeneity;[14] nor of predicting how both would contribute to the contemporary stereotyping of health-related behaviours by well-intentioned clinicians and culture mediators working to enhance clinical competency.[15,16]

Because of these complex difficulties, many today maintain we no longer need Lévi-Strauss's form of structural anthropology, nor require the idea of autonomous cultures, in order to understand, account for, and acknowledge how meaning is constructed in local moral worlds.[17, 18] After all, how do we engender the moral trust required to cross ideological boundaries, if not by a faith in what the Brundtland report in 1987 called *Our Common Future*?[19]

None of us benefits either when locally constructed forms of meaning stand at odds with the now global, post-Nuremberg, discourse on human rights, or when claims to culture are used to create rigid lines of inclusion and exclusion.[20] But being wholly focused on global values can lead to the devaluation of local needs, even amongst those who defend global rights, or perhaps especially amongst them. So projection of the local onto the global has its problems, but so does the obverse.

Whenever we choose the local over the global--anytime we make person-to-person agreements around neighbour-to-neighbour investments in trust--we position ourselves to make both our deepest and most important social contracts, and also commit ourselves to ways of building values that may well not be globally shared. In fact, the local and the global can only be harmoniously synchronized so long as local values do not contradict global ones. That is why culture itself will always be relevant; for when the local does not map onto wider values, the need to be especially attentive becomes critical.

For many concerned about global health, culture is, therefore, less important than addressing political and socio-economic inequality, even perhaps a thing best forgotten. With this view we wholly disagree. In fact, this Commission will contest the view that global equality is of a higher order of concern that culture, and that local culture is principally an obstacle to global behaviour change; for those leaders and heads of charities who speak in the name of social equality have by definition themselves transcended the actual incapacitations of those they represent. They belong to a quite different culture of experience; and because of their chosen day-to-day affiliations, their well-intended suppression of cultural difference—of variation in shared values—replaces a just fear about culture's inclination to polarize insiders and outsiders with a reticence to acknowledge the on-going impact of cultural affiliation: on the local groups they oversee; on the affects of institutional culture on global health advocates and their the organizations; and on the implicit nature of their own cultural values. The problem of suppressing culture is not only

that its negative effects go unaddressed; its positive potential also remains undeveloped.

We must begin, therefore, by acknowledging that culture and its affects are inherently neither good nor bad: culture often helps but sometimes hinders the amelioration of human difference, be it at the level of suffering or of enhanced wellbeing. When it works unchecked to exclude and discriminate, we must understand its taken-for-granted practices so as to modify them. When it works to create moral bonds that enhance person-to-person commitment and empathy, we must endeavour to understand how those bonds can nourish health and provide future models of caring. To suppress or ignore culture on the assumption that difference threatens global agendas, is to mistake the signs of social illness for their symptoms: for new cultures emerge daily in the most modern and global settings to create novel groups and shared forms of meaning that can also be inclusive or exclusionary.

To dismiss, then, that culture is ever-present—that the universalism of science, for example, can be opposed to the local prejudices of culture, or that global goals should take priority over local ones—is to blind us to our own vanity, and to the exclusionary ways in which even the best intended of us can unknowingly behave. In times of social dysfunction those privileged with a public voice may come to share more with one another as an emerging global culture (regardless of their views) than with the incapacitated 'others' with whom they might otherwise share an ethnic, religious, or racial heritage, or even with whom they morally identify. Here, charity itself is no defence: the philanthropist may share more on a day-to-day social basis with her wealthy neighbours who are selfish and un-giving than she does with those who benefit from her philanthropy; just as caregivers may find themselves assuming that their caring behaviours are appropriate even though the outcomes of those practices are appalling.

If we only acknowledge global concepts of equality at the expense of seeing the cultural nature of new and emerging local realities, we limit our capacity for knowing what enhances health and wellbeing at local levels. Much as we talk about suffering and compassion, if we are ignorant of what brings value and meaning to another's life and to the local worlds most inhabit, we are ill-positioned to make life better when illness undermines health. Unless we can redirect our global agendas to address local models that may be at variance with what we take for granted as universal, we have no way of understanding the day-to-day behaviours on which good health and wellbeing depend.

This Lancet Commission on Culture and Health, thus, underlines the need to understand how wellbeing is socially generated and understood, and how socially constructed domains of meaning—that is, 'cultures'—relate or fail to relate to outstanding notions of health and systems of care delivery. Because wellbeing is both biological and social we are committed to the idea that health providers can only improve outcomes across diverse domains of meaning once they accept the

need to understand the socio-cultural conditions that make people, or allow people to make themselves, healthier.

Achieving such an understanding means asking not only what is lost to health care by ignoring the cultures of patients, but also those of caregivers, health administrators, global charities, and scientific researchers. In turn the Commission seeks to evaluate how a closer attention to culture, that is, to local and global systems of meaning, can enhance health in a world of burgeoning health care costs and diminishing resources. We need to examine critically what is known about the relevance of culture in health: about how caring for one another succeeds or fails across cultural divides; about how cultures of care function or collapse in response to changing values; about how health cultures alternately ameliorate or exaggerate inequality; and about how health itself is affected by the presence or absence of general wellbeing in any given socio-cultural group.

This Commission, therefore, seeks to examine the nature of *cultural competency* (how we communicate across cultural divides); the adverse consequences of *social inequality* (how culture can unequally limit the opportunity to become healthier); the structure and function of *communities of care* (how collective activities around health either succeed or fail); and the social conditions that undermine or enhance *human wellbeing* (how personal health relates to the presence or absence of social trust). It seeks less to explore the myriad ways in which wellbeing is constructed in local systems of meaning (the missions of cultural anthropology and of UNESCO) than to ask how a rethinking of the culture concept itself can make us more aware of our own health practices. It is less an inventory of culture-specific definitions of illness and healing (that is, of traditional medical anthropology) than an assessment of why cultural awareness matters in health.

2. Cultural Competency

i. Background

While an interest in 'other' societies has varied widely across human history, the idea of examining how diverse cultural concepts influence health-related behaviours dates back only to the turn of the 20th century and the advent of long-term anthropological fieldwork which exposed the diversity, complexity, and continuity of local health-related practices across cultures.

One of the earliest clinicians to take up the comparative method for examining the influence of culture on health was W.H.R. Rivers, the pioneer doctor and social anthropologist who is equally remembered for his work as an experimental psychologist. Rivers both founded the *British Journal of Psychology* in 1904, and became the first person to use double-blind trials in scientific experiments. Ironically, it was this latter experimental innovation that eventually led to the use of placebos that functioned to eliminate social meaning as much as possible from clinical trials; for the successful introduction of the double-blind control arm as the gold standard

in clinical trials finally eliminated the impact of supposedly undesirable affective responses in determining efficacy and made possible a now-wholly-biomedical field of inquiry. To put it another way: eliminating social affect completely made modern biomedicine possible.

However, for Rivers, culture mattered, and it mattered greatly. In a lecture to the Royal College of Physicians, Rivers was unequivocal about why culture is important to medicine, stating that health and beliefs are

> so closely inter-related that the disentanglement of each from the rest is difficult or impossible; while there are yet other peoples among whom the social processes to which we give the name medicine can hardly be said to exist, so closely is man's attitude towards disease identical with that which he adopts towards other classes of natural phenomena.[21]

Though Rivers may be credited with laying the foundation for the ethnographic study of culture and health, medical anthropology as a taught discipline is much more recent, dating primarily to the advent of multicultural societies, the decline of overt colonialism, and the failures resulting from the unilateral exporting of untenable development models across the globe. In particular, medical anthropologists have repeatedly shown that systems of medical knowledge not only reflect the natural environments within which cultural systems develop (e.g., the use of particular medicinal herbs), but that such systems also reflect local understandings of the person, the cosmos, and what constitutes acceptable (ethical and moral) forms of behaviour. [22,23] While medical anthropologists do still focus on exotic beliefs and practices, today they just as often ask how sets of beliefs (both familiar and unfamiliar) affect illness behaviours.

This Report cannot consider the complex explication of such processes, but it is important to bear in mind how a basic idea—the notion of divine judgment, for example—can influence importantly the way an individual might deal with chronic disability.[24, 25,26,27] Similarly, ways of thinking that at first appear foreign and exotic, may seem less so once time is invested in understanding how complex beliefs and practices overlap to produce coherent and consistent forms of meaning. [28] Even beliefs about the body that may baffle physicians—say, the notion that diseases are the consequences of ancestral actions—may parallel new and emerging ideas in science about genetics, symbiosis, disease vectors, or evolutionary principles. [29] Diverse illness paradigms become, that is, the more familiar to us as we invest the time and curiosity to consider their merits. This is also why many medical anthropologists are clinically trained and many clinicians take up medical anthropology: when illness is at stake, the appreciation of these factors by caregivers and their ability to communicate with those they care for becomes all-important.

These are among the reasons why clinical competence must include cultural competence, but there are others. By the 1970s, the value of clinical communication, and in particular the caregiver's understanding of the patient's individual background, was not only understood; it was also quantified. In May of 1975 the

importance of communication for clinical competence was drawn sharply into focus. The results of a study of the relationship of medical history-taking to physical examination and laboratory investigation was published in the *British Medical Journal*. [30]

The study was designed to compare the effectiveness of person-to-person exchanges in achieving clinical accuracy against both physical examinations and laboratory tests. What emerged was stunning: in 66 of 80 patients (82.5% in the study) "the medical history provided enough information to make an initial diagnosis of a specific disease entity which agreed with the one finally accepted". [30] If 82.5% of all correct diagnoses can be made by taking "a complete history from the patient"[30], why are clinicians so often held to brief and often perfunctory clinical encounters? [31] If over 80% of all diagnoses can be made through detailed history taking (which take at least twice as long as what is thought today to be the managerial gold standard), why hasn't this fact been taken into account when assessing the costs and health benefits of what happens in the clinic?

Some say testing has increased for entirely non-clinical, but quite cultural, reasons. *Scientific American* commentator, John Horgan, puts it bluntly:

> Over-testing undoubtedly stems in part from greed. Most American physicians are paid for the quantity of their care, a model called "fee for service." Doctors have an economic incentive to prescribe tests and treatments even when they may not be needed. Physicians also over-prescribe tests and treatments to protect themselves from malpractice suits.[32]

According to University of Pennsylvania health policy professor, Emanuel Ezekiel, the annual cost of providing health care to the United States rose to over $8000 per person in 2010 and now edges closer to the $9000 mark. Ezekiel invites us to compare this magnificent expense to the entire GDP of China, the world's second largest economy.

> China's G.D.P. is $5.9 trillion (compared to America's $14.6 trillion). So the United States, with a population a quarter of the size of China's, spends just on health care slightly less than half of what China spends on everything. . . . If we continue at this rate of growth, health care will be roughly one-third of the entire economy by 2035 — one of every three dollars will go to health care — and nearly half by 2080. [32,33]

But if laboratory investigations are not cost effective, why are they opted for instead of reallocating resources so that clinicians can spend more time with patients? Is it because health care has increasingly become a predatory business endeavour? Is it because biomedical cultures have fetishized testing practices? In what way, by example, might health-care cultures in the United State be called 'caring' when their fees for services become that nation's number one cause of personal bankruptcy? In what ways are health practices in this instance to be seen as 'caring'? Perhaps most

importantly, why has culturally relevant research—now some forty years old--been systematically ignored in restructuring health delivery procedures and delivery costing?

As the authors of that study concluded long ago:

> Firstly, physicians can allocate the relative time spent taking the history and examining the patient with some confidence, knowing that the extra time spent on the history is likely to be more profitable than extra time spent on the physical examination. Secondly, more emphasis must be placed on teaching students how to take accurate histories in a medical clinic, and proportionately less on showing them how to elicit physical signs. Thirdly, more emphasis must be placed on research into communication between the patient and his physician, and perhaps less emphasis is needed on the development of new laboratory services. Fourthly, there are implications for the planning of medical outpatient departments. There needs to be more emphasis on space for interviewing patients, and proportionately less on space for examining them.
>
> Our findings also have implications for the number of follow-up appointments that need to be given to patients who seem to present diagnostic problems. It seems that if the physician is still in considerable doubt about the diagnosis after the history has been taken and the patient has been examined, then laboratory investigations are unlikely to be helpful.[30]

Good health economists could and should quantify the potential savings made possible in health care by allowing clinicians the time to gain accurate case histories. Providing such time would also affect physicians' own sense of worth, and may even help limit high levels of mid-career disenchantment. However, such cost saving may have a negative impact on investment in for-profit health where clinical care is routinely exposed to service delivery models and where physicians are sometimes referred to as 'healthcare vendors'. As this neglected study made clear, saving time in the short-term will not translate into saving money.

What health delivery culture are we promoting worldwide when we seek to emulate fiscal practices of privatization that require immediate financial returns on investment without any responsibility for long-term outcomes? More will be said of this later in this Report. In the meantime, this Commission calls for a resurrection of respect for caregivers who are wholly capable of saving money and lives if provided the time to demonstrate their abilities to do this.

ii. Cultural Competence and Clinical Adherence

Though competence is generally understood as the ability to implement recognized standards of best practice, what constitutes competence in medicine is far from

clear. [35] Talbot, for example, questions the competency model of medical education, claiming it sometimes rewards lower level or operational competencies at the expense of "reflection, intuition, experience and higher order competence necessary for expert, holistic or well developed practice". [36] By contrast, Betancourt and colleagues see competency as a means of addressing organizational, structural, and clinical barriers in health care access and provision experienced both by physicians and those who seek their help. [37]

While cultural competency training has roots going back to the 1960s, it has only been formally integrated into medical education on a limited basis since the 1970s, arguably in response to calls for new medical models that address the shifting demographics of ethnic migrants. [38,39] In most cases, however, it is yet unincorporated, even if the view prevails that cultural competency can improve clinical outcomes by addressing the needs of those who are 'different' from whatever dominant socio-cultural groups provide care.

However, cultural competency and cultural diversity remain vaguely defined, poorly understood, and prone to being swayed by political rather than educational motives. [40] Conventional understandings of cultural competency that emphasize recognition of racial, ethnic, and linguistic identities shift clinical meaning away from socio-economic factors, as well as away from standard clinical diagnoses. Cultural competency is surely far more than a vague umbrella term that encompasses training in cultural 'sensitivity', multiculturalism, and cross-culturalism. [41] It is also about responsiveness in creativity.

Because being competent involves understanding the rubrics within which barriers to better care can be overcome, enhancing competency should focus on improvement practices and on creating more responsive (and responsible) clinical cultures. Seen as such, competency is highly anthropological, embracing culture less as static and stereotypical than as something "always in the making". [42] At its best, cultural competence, then, serves to bridge the cultural distance between providers and consumers of health care through an emphasis on physicians' knowledge, attitudes, and emerging skills. [41, 43,44,45] Knowing how to negotiate the unknown should, by definition, be a key skill set of a competent clinician, a tolerance that a total reliance on evidence-based medicine has little to advance.

Competence demands attending to both patients' and carers' explanatory models and perceptions of illness and wellbeing. This "Explanatory Models Approach" has now been adopted as a structure for competent practice and includes the following questions:

- What do you call this problem?
- What do you believe is the cause of this problem?
- What course do you expect it to take? How serious is it?
- What do you think this problem does inside your body?
- How does it affect your body and your mind?
- What do you most fear about this condition?
- What do you most fear about the treatment? [46]

Such new frameworks for bridging cultural distance may be the necessary first step in reconciling divergent illness perspectives held by health providers and the sick; but establishing commonalities is not sufficient. Social competency is also relevant when patients and their doctors share much taken-for-granted knowledge; for when physicians and patients share too common a language for the description of illness and disease, the sick may end up with poorer understandings of their conditions where agreement is tacit and incorrectly assumed. [47,48] After all, this is why psychotherapy matters.

Being competent, therefore, needs to include knowing how to develop new ways of evoking clinical meaning, as much as accepting that frameworks of meaning may differ. [49] Whether or not competency principally involves physicians' developing clinical parameters that encourage patients to make their own choices, [50] competency in culture requires production of space within which bridges may be built. [51,52] Caregivers need time to create meaning; and, as we have seen, they can save unnecessary expenses by so doing.

In that being competent means nurturing communication between caregiver and patient in removing barriers to care, [39,45] cultural competence can no longer be viewed as only "a set of skills necessary for physicians to care for immigrants, foreigners, and others from 'exotic' cultures". [43] Moreover, cultural competence should not concern itself exclusively with perceived differences: culture succeeds less when it functions as a medium through which medicine translates clinical realities to uninformed "others", than when it produces new social circumstances that successfully contextualize clinical knowledge. A new technique called the 'Bloomsbury Cultural Formulation' exemplifies such a commitment, and should be reviewed carefully for its potential application in all clinical settings.

Panel 1: DSM-5 and the "cultural formulation"

iii. Cultural Competency and Evidence-based Medicine (EBM)

Evidence-based Medicine (EBM) has as a central goal the reduction of disease burden through tools and measures that have been proven to be both effective and efficient. Because values and behaviour are socially conditioned, understanding the cultural factors that influence treatment seeking behaviours--as well as treatment adherence—is vital for maximising health outcomes. Having a strong evidence base for the treatment of diabetes, for example, allows doctors to reduce the impact of symptoms only if patients actually present themselves for treatment. Likewise, the provision of accurate advice on the management of diabetes will improve the patient's health only if the patient puts the advice into practice in his or her every day life.

But healthcare fails to be maximally effective where significant numbers of patients either do not make use of healthcare to which they are entitled, or do not adhere to

treatment regimens. Type 2 diabetes is a case in point: for a disease whose major causes are known (as are rates of mortality, morbidity, preferred treatments, and modes of prevention), noncompliance rates run between 40-60% in the most privileged economies[66], with many studies regularly showing that only one out of three patients adhere to therapeutic recommendations[67]. Evidence-based approaches to practice have long recognised that research evidence and clinical expertise alone are not sufficient for achieving optimum outcomes. Treatment decisions frequently involve weighing risks, such as deciding between a more aggressive or a more conservative approach to managing a disease by care provider, by patient, and by health services and funders. Good quality care must integrate "best research evidence with clinical expertise and patient values."[68]

It is now increasingly recognised even within the narrowest biomedical models of healthcare that some form of cultural competence is required to frame and present information in such a way that patients are able to make choices in line with their life goals, their cultural values, and their beliefs about their own agency and the consequences of their actions. From the caregiver's perspective, it is no longer acceptable to ignore cultural factors by labelling them 'nonclinical', as much of what is clinically possible is set by those very factors. Patient empowerment and related self-help strategies are useful only for those who feel they have the capacity to affect health by taking responsibility for themselves; for those who do not feel—or are not—empowered, quite different strategies are required to enhance wellbeing, and these in general require opportunities for person-to-person engagement and trust building.

Because competency is about identifying and interpreting the new and unknown, it has not been furthered, and may well have been hindered, by an exclusive focus on medicine's evidence base. Though developing best practices out of what has already been demonstrated is laudable, an obsessive focus on evidence also means valuing what is known at the expense of what is not yet known, what may not be known, or, indeed, what may not be clinically knowable. A "thing in the making" by definition cannot be fully known by simple recourse to existing formulas or normative paradigms.[69] Curiosity is key here to innovation. Using normative decision-making techniques at the level of culture can, therefore, have disastrous consequences. This problem is clearly demonstrated by the many well-intentioned competence-enhancing initiatives that teach culture reductively, exacerbating already harmful stereotypes. [69,70]

While anthropologists largely retreat from approaching culture as stereotypical and fixed, many medical educators may not. Medical school initiatives and caregiver training programmes often reduce individual behaviours to broader stereotypical formulations, or at least encourage such stereotyping by applying specific behaviours to categories of people. There may without doubt be broad truths upon which such generalizations are based; Germans do, by and large, relate low blood pressure to a weakening of the heart and fear it more than most. But generalizations must be accepted cautiously, realizing that individual responses to norms vary widely. A principal concern of this Commission, then, is the question of whether

something as dynamic as culture can be effectively known from within the highly normative paradigms of engagement that are central to medical education and the treatment scenarios it promotes. This is why we take it as essential that culture, including institutional cultures, be examined carefully; for wholly new structures of care may now be required.

In seeking to establish what is and is not culturally normative, broad generalizations about culture run the risk of defining it as a pathological condition--applying normative stereotypes indiscriminately to diverse beliefs, patterns of acting, and systems of meaning. Sensing a shared value, that is, tells us little or nothing about how a member of any society may or may not respond to that value. Cultural competency courses may inadvertently strengthen culturally associated stereotypes that physicians hold about patients, and thereby make it more difficult for doctors to perceive their own biases and the impact these may have on diagnosis and treatment decisions. [71] Training courses need, therefore, themselves to be developed 'competently'.

At its worst, cultural competency training is, then, "made synonymous with ethnicity, nationality and language", [46] and taught as though it can be satisfied using a checklist: do this, not that. Under such conditions, doctors who have been trained in cultural competence may often misattribute cultural reasons to patient problems, rather than recognize that patient difficulties can be equally economic, logistical or circumstantial. [46] Many a social inequality, that is, may be hidden under the aegis of culture.

In sum, those studying healthcare need to be redirected towards an appreciation of what is unknown, and the processes by which new knowledge can be obtained. Teaching culture as a fixed perspective on illness and clinical behaviour risks not only promoting mediocre care, but proffering poor strategies for addressing problems that emerge in socially complex treatment environments. Such practices and assumptions are especially harmful because they are exacerbated by healthcare students' insecurities about knowledge and evidence. They are also made the more harmful when educational hierarchies encourage students to emulate authoritatively their senior doctors who themselves may be at odds with the relevance of culture. It is to this last difficulty that we shall now turn.

iv. Prestigious imitation

The importance of imitative practices in learning to adopt new social roles was identified long before sociologist, Irving Goffman embarked on his famous studies of status. [72] Half a century earlier French social theorist, Marcel Mauss, had already introduced the concept of prestigious imitation to describe how neophytes learn to establish authoritative voice. [73] What Mauss had in mind was a concept that could describe a learning experience in terms of its social, physical and psychological elements. For the purpose of this Commission it is his emphasis on how social knowledge patterns physical practice that matters.

First of all, let us be clear: prestigious imitation need not be understood negatively; teaching cannot take place without role modelling and without student aspirations for self-improvement that focus on the exhibition of excellence by their instructors. Throughout life we all come to know the merits and hurdles of role modelling. Yet, in shaping junior doctors' interactions with patients holding diverse models of illness and wellbeing, the exaggerated prestige imitation of senior physicians can not only lead to an ignorance of the unknown, but to cavalier attitudes about what needs to be known. [74] Few anthropologists, in fact, have not been subjected to stories from medical students about being warned by senior staff not to "waste time" studying culture.

While imitative practices often cost doctors-in-training their psychological autonomy, the damage done to improving health outcomes can be incalculable. [75] Emphasis on the presentation of cases by medical students to training faculty, the observation of student assessments of patients by superiors, and the systems of recommendation that lead to future professional opportunities all contribute to medical students' overemphasis on gaining acknowledgement through imitation. [23,76] Medical schools may profess to have global visions, but their daily activities are more often than not parochial.

Evidence-based medicine has done little to contain this problem, in spite of its limiting professional hierarchies among senior physicians. Rather, it may actually have worsened cultural awareness. Making students focus obsessively on what is already known, rather than what is not yet known, reshapes medical training and practice profoundly.[77,78,79]As one medical educator argues, we long ago recognized

> that patients are the ultimate arbiters of whether an outcome has been successful. This change in practice followed the realisation that people who turn to general practice for help rarely present with a single 'evidence-based illness' that can be neatly categorised according to the results of a randomised controlled trial. Such trials, almost by definition, exclude the vast majority of practice populations whose age, sex or co-morbidities might 'spoil the science'! [80]

Though students may now have the right to opt for the evidence base over the assumed authority of senior doctors, patients with diverse understandings are harmed directly by the assumption that competence can be fully discharged by reference to what is known and published. Here, the focus of prestige shifts from imitating senior colleagues to imitating what has worked elsewhere. This problem is not helped by severe time constraints placed on clinical encounters and the tendency to order expensive tests to avoid litigation resulting from incorrect diagnoses.

For undergraduate medical students in many countries, interpersonal skills are taught in classroom settings. In some cases, a weekly, hour-long session continues throughout a student's training and drills students in interactive issues that arise in clinical environments. While students are invited to engage patients throughout

clinical training, many neophyte physicians take only a single class, or courses that run for a few hours over a limited number of weeks. [81] In other cases, much less is required of students, even though doctors-to-be express anxiety about their inability to behave constructively in clinical encounters. Many even claim that such courses are useless, stating they learn more about how to comport themselves as professionals by imitating older doctors and by following institutional rules of conduct. Success here may be as much driven by a desire to fit in with a clinical culture's modes of practice, as by patient need. Because of this social reality, adherence and its relation to cultural factors in clinical behaviour are often seen as beyond the brief of clinical staff.

When employees in institutional settings feel threatened and insecure, they work to whatever rules they feel governed by. In medical training this means being safe, not sorry. As a result, students again and again openly prioritize the behavioural certainties of lower level, imitative and operational competencies over more open ended, exploratory and interactive ones. Students are encouraged to be certain in particular ways, and learn and feel comfortable with those levels of engagement. Uncertainty in medical practice is equated with bad medicine: knowing is good; not knowing, dangerous.

Thus, any allusion to the merits of higher-level social competencies—ones that might acknowledge the need to bridge anxieties and perceived differences—are systematically devalued. Those who opt for engaging patients in exploring health beliefs and attitudes, or invite patients to inform diagnoses, are at best considered "different" and at worst "incompetent"[82]. Patients are sometimes welcomed to help implement treatments, but they are hardly considered useful in explaining why illnesses manifest themselves as they do. The patient's point of view becomes relevant only as a basis for securing compliance.

How, then, can physicians become more culturally competent if there is little or no room for embracing uncertainty, and if hospitals are only places where evidence is measured against biomedical decision-making? How can physicians-in-training learn about the importance of the unknown—of how new knowledge is produced--if clinical training is largely subjected to short-term, outcome-oriented algorithms? If students are assessed only on what they know--rather than on their approaches to what they don't know—how will new forms of competency ever emerge?

There are answers. When medical students develop competency skills through medium and longer-term immersion in discursive learning contexts, they increase dramatically their ability to become culturally competent. Developing new forms of competence takes time: first, because sensing constructively the depths of one's own ignorance cannot happen overnight; and second, because learning to be brave means unlearning certain patterns of imitative behaviour. In fact, the more deeply those patterns are embedded, the more time one needs to accept their limitations and adjust one's behaviours accordingly. Though evidence-based medicine was meant to replace prestigious imitation in medical training,[83] such a transformation has not occurred: prestige hierarchies remain critical to medical training even if they

no longer reside in a clinical gerontocracy. There can be no enhanced competency, that is, until the cultural specificities of particular training conventions are also acknowledged. Moreover, as open access to diagnostic information increases, doctors will need to redefine their roles as caregivers and as advocates for patients who now often approach clinical encounters with a diagnosis in hand. This is a hard lesson to learn from the inside, and especially for neophyte doctors whose professional identities are not yet enough secure to admit the possible creative limitations of dominant clinical attitudes.

The challenge presented by cultural competency, then, has little to do with either culture as a fixed identity or with competency as a professional certification. The challenge, rather, concerns how invention is undermined, uncertainty suppressed, and biology exaggerated in medical education. Because most competence training more resembles discursive exploration than high-order intuitive practice, [36] various other strategies must emerge for articulating what is lost to health by ignoring culture. These strategies should seek to address by different means the question of how one engenders a concern for the unknown and a curiosity about developing new responses to other ways of thinking. [84] Establishing a common ground with those in need cannot take place where premature closure of clinical engagement limits the possibility of both communication and caring.[85]

While there are probably as many responses to the cultural competency question as there are doctor-patient courses for physicians-in-training, the idea of competency has been reshaped into calls for clinical humility, cultural safety, and transnational, socio-economic, and structural competence.[86−91] However the question remains: how do we provide more long-term engagement for students and provide that engagement at a time when the merits of such a commitment do not escape them? Students do not need to be told about how they are failing before they have ever succeeded; students need the space to cultivate options that are real to them that they would otherwise not have thought of.

The conceptualization of culture as fully knowable may function as a security blanket for physicians—offering doctors a measurable standard by which they can judge themselves in the face of perceived difference; but complex clinical encounters are, for that very reason, frequently avoided. [92] This tendency is especially prevalent in teaching environments where doctors in training will often privilege treating patients who make it possible for them to garner respect from superiors. [93, 94] Because much of medical education is based upon the display of certainty, this Commission advocates teaching cultural competence to medical students through long-term, reflexive, exploratory, practice-based approaches, rather than through short-term, norm-seeking ones.

Sustained training transforms the learning experience into a problem solving activity and leads to greater retention of concepts.[93, 94] Several physicians who have studied medical anthropology for at least a year report that anthropological study caused them to problem-solve differently. [95] How they define this difference is diversely expressed, but the bottom line is clear: physicians become more culturally

competent when they receive relatively varied comparative educational opportunities that challenge their ideas, encourage reflexive thought, and make their 'cultural education' more robust.

v. Mistaking Compliance for Competence

Many medical students overtly express the belief that equality of care is best ensured by a doctor's refusal to employ ethnic, racial or religious characteristics as clinically salient diagnostic criteria. In so doing these students confirm Dogra's claim that the *a priori* acceptance of racial and ethnic distinction by doctors is by nature problematic. [40] Yet, problems do arise if doctors insist that patients present themselves in ways that doctors understand as culturally neutral. Asking female Islamic patients to remove their veil during diagnosis, for instance, or requesting that a family of Hasidic Jewish patients not to bring food into hospital may seem only to ignore the relevance of religious affiliation; but those who find these practices meaningful also consider such requests hostile. Though blaming culture is problematic, that culture is factored out of clinical settings may merely indicate some acknowledgment of the extent to which it is inherently so difficult to assess.

The emergence of financially incentivized healthcare has meant that healthcare providers and their students are encouraged to equate competence with clinical compliance. In such settings culturally competent doctors are those who learn to use the social capital of patients, families, and communities of people to achieve measurable clinical outcomes. These models, which increasingly conceptualize doctors as health care vendors, only succeed when goals set by managers and administrators are similar to those of patients. They will not solve problems generated by social difference.

Rigid conduits for administering care in which doctors invariably emerge as non-patient oriented replace personal relations and clinical freedom. Mid-career ennui and depression now surface as norms in care delivery, as patients' distrust of providers magnifies uncontrollably. [96] On the patient's side, care recipients increasingly perceive novel 'patient empowerment' programmes as attempts to devolve responsibilities from caregivers to the ill themselves. It is the examination of culture in health delivery that makes this conclusion unavoidable; one only has to face how packaged service programmes widen gaps for those who cannot access them, leaving the poor to be blamed while the wealthy are treated as consumers with assets to spend. In HIV public health messages, for instance, the infected in well-off countries are repeatedly informed that their infections are manageable and that they are healthier than they may think; while public information campaigns in the global South barrage the "uninformed" with messages about how they are less healthy than they imagine. [97]

Under such conditions what can students be taught? In the worst cases, students are taught that patients will agree if doctors speak positively, look the patient in the eye, and exude whatever warmth and closeness may be required to cajole the ill into following therapeutic instructions. Though such enforced behaviours may sway

patients under specific clinical circumstances, they offer clinicians little indication of how patients will behave outside of the clinic, because caregivers have not been afforded the time or opportunity to consider the drivers of patient wellbeing.

Thus, while patient-doctor training can produce an immediate expression of compliance on the part of patients in doctors' offices, doubts about treatment efficacy may re-emerge soon after patients leave clinical settings. Polite patients who go on to ignore the agreement the physician thought had been established in the clinical encounter are later labelled as "non-compliant" for having appeared to have broken a clinical agreement, when if fact it was the physician who mistakenly thought he or she had convinced the patient to comply.

Such misunderstandings do little but reinforce socio-cultural stereotypes. [98] While humanitarian concerns may, then, drive competency training, compliance problems are sometimes viewed as a managerial annoyance. Active patient and user involvement can build bridges to better care when other compliance and adherence strategies fail. [99,100] This is a primary reason why social encounters cannot be wholly replaced by technical innovations; for in the best cases student health providers (doctors, nurses, midwives, therapists) learn that therapeutic encounters are events in which outcomes can be enhanced by genuine caring, and that respect and esteem are key components in assisting the unwell to discover new meaning through the trials of suffering that illness creates.

Given the brevity of competency training and the everyday limitations placed on healthcare providers, one might reasonably ask whether a little knowledge is a dangerous thing. The problem here is compounded by short-term managerial demands for outputs, creating little time for cultures of care to emerge. Unpacking such goal tending takes time, trust, and patience--therapeutic time for both patients and doctors, but also for managerial overseers who otherwise haunt clinical encounters leaving caregivers and patients fearful, if not depressed. In this regard, the system itself needs on-going therapy, as health administrators themselves are in much need of critical study.

Such large-scale problems in the 'culture of care' are not easily addressed, and new approaches to teaching competency in medical schools, therefore, vary dramatically.[39,81,101] Rethinking cultural competency is a challenge. Cultural competency is caring competency. Not only does it involve an awareness of diverse patient needs; it also demands some awareness of the chronic dimensions of medicine's inherent hierarchies and hegemonic practices. Rural primary care doctors, who often openly acknowledge the importance of social work, regularly complain about their treatment by medical centre colleagues as time-wasting, second-class professional citizens.[76,85] Nursing has become so undesirably subservient that some countries cannot survive without the massive infusion of immigrant caregivers into their workforces. Even the invention of family practitioner sub-specialties has not helped, [102,103,104] frequently leaving family practitioners to be lumped in with "countercultural" or other forms of "alternative" medicine. [105]

In short, cultural competency is the tail end of a much bigger problem having to do with a lack of education and basic cultural awareness on the part of medical educators themselves. If medical schools must make ends meet through indirect revenues on grants, on profit-making clinical services, and on philanthropy, why should they be principally focused on education, or health promotion, or a curiosity about the great unknown that other viewpoints represent? [106] Cultural awareness is, therefore, not an adjunct activity for healthcare trainees, but an increasingly essential element of training, and of research about training, which needs to be fully and centrally supported as an educational priority.

Medical training institutions must undergo a profound change: not only must they become more aware of their own cultural practices, but they uniformly must take culture more seriously than whatever subspecialties are currently drawing the most attention of those in training. Moreover, they must show clear evidence that such initiatives are substantive and genuinely supported by training staff. Training institutions must also stand up for the rights of future caregivers to learn and implement new ways of providing care through training that is extended and exploratory. Students deserve more; and programmes must allow for such a shift in medical training. If professional schools object on the grounds that students already have far too much basic science knowledge to absorb, then new care mediating professions must emerge on an equal footing—in terms of academic status and financial remuneration—to fulfil the needs of those who receive poorer care.

3. Inequality and Health Delivery

i. Dynamic Inequalities.

Because societies (cultural, political, or professional) are built on consensus and conventional, often taken-for-granted practices, they can become especially vulnerable when they feel weak or overtly challenged by perceived outsiders. In unstable times there is a distinct tendency for groups small and large to focus on social differences rather than on similarities. [107,108,109]

The ancient practice of understanding who 'we' are by differencing ourselves from perceived 'others' may in part be what makes us social and permits local trusting alliances to emerge; but assimilating those perceived to be 'outsiders' (however one may define them) becomes problematic in moments of political instability, social insecurity, and overt crisis. [111–116] Americans who once invited in the 'tired' and 'poor' may attempt to ring-fence themselves after 9/11; and in the UK, Prime Minister, David Cameron, might even proclaim that "multiculturalism has failed", and ask that physicians become gatekeepers for identifying irregular migrants.

Panel 2. Multiculturalism and the Limits of Governance

But when societies feel less vulnerable they are naturally less concerned about what they perceive to be outside influences: [122,123,124]Gorbachov announced the

transformation of the then Soviet Union by releasing dissidents and inviting radical thinkers to Moscow to celebrate Russia's new liberties; and Japan transformed itself from a wholly isolationist empire into a country that confidently assimilated many foreign ideas and practices. The important point for health is that recognizing culture as troubling occurs especially when groups feel vulnerable, like the hurt from a wound when one is conscious of the pain it creates.

Distrusting perceived outsiders, however wrongly stigmatised, is historically the first way in which groups set themselves up in opposition to one another, and by which they redefine themselves. The same is no less true of health-care workers when they discriminate against other kinds of health work as less important; when health authorities perceive non-biological interventions as expendable; or when global health advocates inveigh against local practice as insufficient. This is why cultural inclinations function in health both at local and at societal levels, and why the tendency to discriminate in health is also apparent when citizens perceive carers as adversaries, as allies of the state or private profiteering when policies conflict with local family concerns and community values. As long as business is characterised by self-interest, there can be no other way, especially when times are hard.

Why then is culture such an important part of health, if it unites groups, but often also sets them up against one another? The answer is simple: because health in a social sense is also subjected to cultural values. For example, while contemporary biomedicine is quick to see itself as universal, [125]in some countries as much as 85% of a population self-medicates without the benefit of biomedical care—that is, does not participate directly on a daily basis in biomedical culture and the social networks of professional biomedicine. [126] The majority of the world must self-medicate because provision is otherwise simply absent.[127,128] Though that 85% may rely on fake and out of date drugs, or on products the effects of which are unknown, they nonetheless may have strong views about wellness. The idea that medicine is healing the world, in other words, is also a cultural notion that is subject to the oscillations of social security and insecurity.

Though we assume that those who work to enhance the wellbeing of others would be much needed in moments of social unrest, there is a long, if forgotten, history of victimizing caregivers. Doctors were horrifically persecuted by the Pol Pot regime in Cambodia, as are Red Cross volunteers in war-torn regions. In many poor countries carers are perceived locally as having unfair advantage, possessing access to what others desperately need and not always working to Hippocratic values.

But it is not only in conditions of extreme social duress that the tendency to see caregivers as opportunistic can emerge. In un-restful but more stable contexts, discrimination is still is at work (albeit more subtly) when a society blames health care providers, educators, and even its own young for wider social problems. Such scapegoating is a key measure of broad social instability, and it can occur in unlikely places well outside of courtrooms where doctors now increasingly find themselves.[129]

Though a new generation of physician-anthropologists might initially appear to hold the answer to the health care needs of culturally diverse populations, the reality may be quite different. On one hand, the idea is sound: anthropologically trained physicians have contributed significantly to the transformation of caring practices as they relate to vulnerable peoples worldwide. But the problem is complex and, as it turns out, complex for rather unexpected reasons; for when groups feel vulnerable they as often resent as respect those who have managed to transcend life's daily hardships. Supporting elites who actively subscribe to, or passively consent to, their own upward mobility does not necessarily help the health needs of unhealthy societies.

This is one reason why countries with weak health infrastructures sometimes emulate, against what may seem rational, exceedingly expensive health delivery models that encourage personal gain in the absence of social equality: because they subliminally or overtly have given up on collective good will as a driver of social welfare and opted for encouraging entrepreneurs instead. Under such conditions, those who aspire to be recognized in the face of widespread instability and suffering may be held in suspicion by others who see themselves as staying on to assist more anonymously the needs of families and neighbours.

In a healthy society, 'outsiders' and 'achievers' can nourish, inform, and reshape conventional practices; a society can withstand the grandstanding of those who claim to represent its needs in universities and in positions of political authority. But in insecure cultural moments, many will fear both newcomers and the upwardly mobile who are now seen as colluding in asking more from those in need than they feel they can give. Under such conditions a group's altruism is seriously jeopardised by its own social insecurity. Both caregivers and educators may find themselves targets of resentment; because when a society becomes quite unstable, those who seek out advancement and prestige—especially in education and in health—may be perceived to have placed themselves above a widespread disillusionment.

Understanding, then, how culture plays out in less well societies can allow us to go beyond simplistic arguments that focus exclusively on global financial equality, while also holding important answers to apparently overwhelming challenges. For when a society at large feels highly vulnerable it may not be capable of producing the trust required either to tolerate difference or even to tolerate its own upwardly mobile. At the level of culture and health, the tendency is perfectly logical: when groups, both local and national, find themselves for whatever reasons in flux and unstable, it is easy to confuse personal gain and social commitment.

As healthcare's upwardly mobile succeed—be they doctors, educators, or cultural anthropologists—they may well be seen as doing so at the expense of those they purport to represent, participating as much in society's inequalities of achievement as changing them. In one long-term study of more than 240 primary care doctors in rural North America, physicians reported spending up to 60% of their professional time on what they felt to be important, non-biomedical attention to otherwise anonymous patients, while openly expressing resentment for being treated as less

competent by hospital and university based specialists—including not only by their 'more highly trained' peers, but also by health administrators who punished them financially for spending too much time with their patients.[85] Is it any wonder that resentment exists towards those with voice and authority in so-called centres of excellence?

ii. 'Sick' Societies

In the "Problems of the World" the United Nations long ago summed up in a worldwide survey the global price of modernity. Asked to provide single words that corresponded to the problems characteristic of various social structures, respondents painted a sorry picture. For "culture" the response was "rootless"; for "politics", "powerless"; for "economics", both "jobless" and "ruthless"; and for the "environment", "futureless". Asked what one word summed up the condition of the modern world and the sentiment could not be more troubling; "meaningless". Optimism is surely called for here; but let us not be naïve.

As personal mobility becomes increasingly released from local meaning, the disjunction between what people value morally in their daily lives and what they perceive to be the values of society at large can diverge sharply. This disjunction in values place people at odds with their day-to-day environments, suggesting to them that whatever wellness is to be had is either at odds with dominant social trends, or not to be found in things local. In short, they begin to see society, their local consensual networks, and even themselves as unwell, causing them either to retrench or to abandon the local for other perceived opportunities. This is one strong argument for contemporary massive urban migration.

Classical social theory calls this condition a state of *anomie* (a lack or decline of ethical standards), a kind of "psychological as well as physiological weariness, disillusionment, disappointment, psychic pain, and a tendency to grope at random, which in turn brings on still other crises, until life itself seems 'intolerable' ".[130] It is a condition not only common today in many societies worldwide, but now also pervasive amongst mid-career healthcare providers.[131,132]

Social scientists recognized long ago the dangers of combining social disillusionment with social expressions of ego and self-interest—a problem that can escalate when unstable social conditions seem threatened by the health and welfare needs of "others"—that is, of minorities and especially immigrants. At such moments, a group—a community, a culture, a society--cannot feel confident about its own resilience because it finds itself caught between its own anxiousness and its need to overstate its identity. It becomes, in other words, exclusive.

Figure 6. Contemporary Swiss anti-immigration poster. "Excessive damages! Stop Mass Immigration". In times of instability, migrant are often targeted for the failures of society. SVP

Under such conditions, professional prestige and prestige imitation fail as effective goals for those wishing to reduce health inequalities, because the new cultural and socio-economic affiliations (that those who seek prestige are seen as subscribing to) place the upwardly mobile—even global health advocates—at odds with the very groups they might otherwise assist and represent. What is called for under such conditions is something rather culturally different—an elevation of the status of those who do not step forward when called to positions of prestige: namely, local caregivers both clinical and social. But since such a celebrating of self-denial seems unlikely in the extreme, new forms of caring must be developed that are not themselves directly bound up in the very health systems that are so in need of transformation.

This is one important reason why a concern with culture should supersede concerns about social inequality that only examine the socio-economic determinants of health. When social conditions appear unhealthy in broad terms, those who thrive may be seen as colluding with or profiting from social dysfunction, regardless of how they may individually wish to reshape from within various hierarchical forms of prestige that erode local meaning.[13] Indeed, people may see status as the problem, not the answer. This is why local primary care physicians may come to distrust physician-anthropologists as much as they feel at odds with distinguished consultants and subspecialists. It is also why new forms of community health intervention must be envisaged and supported on an equal basis with clinical medicine.

Panel 3. Masking the Limits of Biomedicine: Social Inequality and Prestige Imitation

A second reason why professional prestige imitation in health care should be reconsidered within the framework of collapsing health delivery structures is that the prioritising of global issues can divert attention, and hence resources, from local places where wellbeing and continuity are generated in face-to-face human encounters. Though modernity has made some global health problems also local ones--and global health itself the 'big issue' in health—the elimination of health services at local levels has had devastating consequences, leaving communities without the resources by which they define community, and conveying to both citizens and healthcare providers that their health futures reside in urban areas where such services have now been sequestered. Here, research is required to assess the impact not only of educating healthcare professionals to believe that their best opportunities are to be found at prestigious 'centres of excellence', but also to face openly the impact of such practices on basic social trust at local levels. How can marginalised groups trust advocates when in hard times advocates themselves cling to prestige hierarchies and the centres of excellence in which such hierarchies thrive?

This lack of basic trust is what economist, John Maynard Keynes, called the 'paradox of thrift'. Governments cut back precisely at the time when the private sector can only think about profit. Healthcare providers would do well to consider his views of the long-term damages of what appear to be short-term gains—when governments

present a publicly structured system of welfare behind which lie a plethora of for-profit private providers about whom the patient knows nothing and in which they express no trust. This structural relation is precisely the opposite of what Keynes recommended: for now, behind a curtain of public interest, lie multiple profit-makers whose principal requirement is to make profit for investors by saving—that is, giving less—and, when necessary, promoting themselves through mediocre assessment processes and poor-quality evaluative research. [135]

The evidence for both is not hard to find. When the face of publicly funded welfare masks guaranteed private profiteering, those in need of care cannot establish trust. In fact, they feel betrayed.[135,136] Is it any wonder—where what is private and what is public is hidden, and a general disillusionment prevails—that there is sometimes little opposition to public-private partnerships? [137] When people feel disillusioned, they lack the motivation to make changes; they simply feel overwhelmed.

Today, the question must be asked if the decisions of governments and the WHO to promote public-private partnerships in health are as much in the best interests of recipients of care and the cultures of the communities cared for as they are in the interests of the cultures of private providers and their lobbyists. That health care functions in the public interest is now as contestable as its business prospects are undeniable. Health has in many countries become a big business and an extremely profitable one, especially when business sees bodies as commodities to be exchanged and bartered in all of their parts.[138]

Panel 4. Health Tourism and the Moral Economy of Death

In short, there can be no trust in government—no 'big society'—when what citizens see before them is the on-going erosion of local needs in favour of life under the brighter lights of urban, national, and global stages. The issue here is not only about the dissolution of the welfare state and the damaging effects of current neoliberal thinking; also at risk are nations whose human resources in health are eroded or destroyed by an almost ceaseless draining of skills and services now directed towards wide scale health migrations on the part of those seeking services, those providing them, and those employed by providers.[144, 145] The abandonment of local health needs in favour of supporting centres of excellence must be replaced by new models of excellence, and especially by training programmes that value and valorise the guaranteed devolution of excellence into local communities—be they urban or rural.

ii. Galtung's Structural Violence: The Cultural Downside of Distrust

Focusing on 'structural violence' has allowed social scientists and policymakers to understand the ways in which structures constrain agency and thereby place people in situations of enhanced vulnerability. However, while work on health and structural violence focuses on the human rights categories of poverty, race, gender, and socio-economic inequality in shaping vulnerability to disease, other broad structural factors are equally critical. Diffuse, dislocating, and destabilizing factors (such as shifting labour needs, climate change, overpopulation, and resource

scarcities) all transcend the capacity of individuals to control their destinies. [146] These latter factors often, therefore, remain hidden when one focuses solely on human rights discourse and the empowerment of vulnerable peoples.

Examining the complex interrelations of epidemics, for instance, and the way that risks are compounded by amoral drivers can be lost when we fail to acknowledge the synchronous, "syndemic", nature of factors requiring "systematic ethnoepidemiological surveillance with populations subject to multiple social stressors (e.g., poverty, discrimination, malnutrition, stigma, lack of access to medical treatment)". [147] As Waquant says, the problem of reducing human strife to sweeping statements about structural violence is that it

> conflates fully fledged domination with mere social disparity and then collapses forms of violence that need to be differentiated, such as physical, economic, political, and symbolic variants or those wielded by state, market, and other social entities . . . . Nothing is gained by lumping under the same heading "steep grades of social inequality, including racism and gender inequality," that may operate smoothly with the consent of the subordinate with, say, wife beating and ethnic rioting or "brute poverty" with, say, invasion and genocidal policies. [138,148,149,150]

Still, at a more general level, the notion of structural violence is useful insofar as it immediately brings to our attention the lived reality of contemporary health care predicaments and the ways that unequal distribution of power systemically disadvantages people by constraining agency and creating disproportionate life choices and opportunities, as physician-anthropologist, Farmer, principally has argued.[17] Furthermore, it cogently points to the various limitations of various theoretical and practical approaches to contemporary health and disease, especially as they are understood from the profession-specific positions of social scientists, economists, clinicians, policymakers and public health professionals.

As Kim et al put it:

> because the patients are poor and the treatments expensive, the logic of "cost-effectiveness" had stalled innovation in treatment and control of HIV and drug-resistant strains of TB and malaria. . . . Rather than assume a fixed universe of limited resources that makes only the simplest and least expensive interventions possible in poor countries, we must search for a more appropriate share of rapidly expanding global resources… Any barriers that currently exist to comprehensive global TB control, either in the minds of policy makers or in the "real world," must be brought down. [151,152]

The same must be said for the alarming growth of global disease burdens. Other MRSs and dengue, for example, provide clear cases in point where lack of public health foresight has allowed burdens to grow alarmingly and disproportionately.

What consistently emerges from the literature on structural violence are complex interpersonal and sociocultural matrices in which individuals are variably embedded in attempts to access or retain care. Within such struggles, clinicians, biomedical researchers and policymakers, represent diverse standpoints, often blinded to the complex social structures and specific cultural mechanisms that shape and inform everyday lives. The shared goal here is to make visible the hidden voices of injustice in order that we might shift health services away from the structures of privilege, [17,153,154] revealing dissonances between globalizing discourses and localized social realities that so often end up prolonging personal and collective tragedy. [155]

Under ideal conditions, the global and the local merge. Policies that redistribute wealth (such as those promoted by Wilkinson and Marmot, [156] Sen, [157] Nussbaum [158] and others) so closely overlap local needs that ethnographic research can provide a unique standpoint from which to begin to explore the determining, if often ambivalent, relationships between local concerns and global practices. [159]
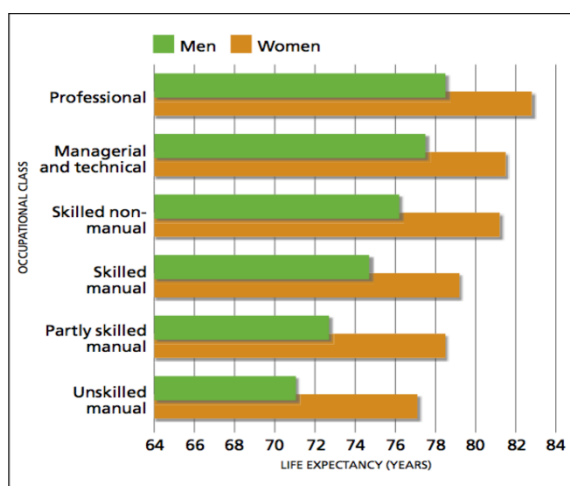

Figure 1. Occupational class differences in life expectancy, England and Wales, 1997-1999.[160]

Manderson et al put this succinctly: "a social science perspective on diseases of poverty is critical to ensure that equity remains an underlying principle in policy development, research, advocacy/dialogue, legislation, resource allocation, planning, implementation, and monitoring of programs and projects". [159]

iii. Problems with the Structural Violence Model

In many cases attempts to legislate equality have not worked as well as one might have hoped. More than thirty years ago Littlewood and Lipsedge reported on the longstanding inequalities in the psychiatric treatment of blacks (African and Caribbean) in the UK. [161] Why do racial minorities (and especially so-called 'Afro-Caribbean' groups) in Britain have much higher rates of diagnosed mental illness than the general population? Why are these rates so much higher in migrant communities than they are in these groups' communities of origin? Does the act of

living in a transnational setting create mental illnesses (structural violence in the community), or is the trend to over-diagnose a physician's concern (the result of latent racism embedded in clinical practice)?

What has happened over thirty years? In spite of this longstanding awareness and reams of regulation, discrimination remains almost unchecked. Blacks outnumber whites and members of other racial groups in some UK psychiatric intensive care units by a factor of 6 to 1. And the statistics are no better in many other democracies. To cite one example, a study of life expectancy of Black Americans demonstrated that racial disparities in the delivery of heath have not decreased substantially, leaving black Americans to live on average 6 years less than whites. [162] Decades of work have "documented that whether bounded by ethnic or racial identities, immigrant status, English language fluency, educational attainment, poverty, low socioeconomic status (SES), or urban/rural residence, minorities and the poor receive less care and poorer quality care than their middle class and educated compatriots".[162] To cite another, Type-2 diabetes rates are so high in indigenous communities (above 50% for men over 50 years of age amongst some Native American groups), that local leaders openly describe the sequestering of indigenous peoples into reservation social housing as a form of cultural genocide. In the Pacific Island Countries and Territories (PICTs) the situation is no less horrifying, especially when considered against the background of groups in which this illness was virtually unknown.

Panel 5. Diabetes in Melanesia (New Caledonia): The 'Cultural Genocide' of Indigenous Groups

Though measuring differences in treatment according to race remains an important endeavour, the authors of this Report restate the need to gauge the effect of interventions as they relate to the agency of those being treated. "Unless differences in medical care according to race reflect the quality of care and meaningfully affect patients' survival or quality of life, the existence of racial disparities will remain of far greater interest to social scientists than to policy makers and physicians". [164]

For all the on-going debates about their meanings and interrelations, the concepts of agency and structure continue to resonate across disciplines and fields of enquiry. Many social scientists agree that if humans everywhere are to be granted agency, then it must also be accepted that the expression and exercise of will needs always to be contextualised. Another way of putting this is to suggest that agency is inevitably 'structured' though not always structurally determined. People's everyday lives and the limits of their decision-making, in other words, are in part shaped for them by structures. Such structures might, then, be said to act as causal mechanisms in propitious circumstances (sometimes the potential impact of one set of mechanisms is annulled by another); often, however, structures are 'hidden', as when culturally-driven ideas are assumed within a group holding them to be universal. Arguably, it is a primary function of education, if not of all educational systems, to enhance our reflexive awareness of those structures and their consequences.

Pioneer 19th-century thinkers about health and its mal-distribution, like Engels and Virchow, regarded those who defended or promoted structures that systematically worked to their advantage and to the disadvantage of others as 'murderers' (for example, for Engels the Manchester factory-owner 'murdered' his employees by exploiting them to the point of making them sick and shortening their lives). [167] This kind of 'structural violence' is easier and less tendentious if acknowledged in past times or distant places. But it clearly applies no less to contemporary Western financial, business, political, and other elites than it did to Engels' fellow-factory owners.

An alternative way of articulating this point is to say that people's life-worlds are structured by mechanisms that they are often largely unable to affect, and the elucidation of which is opposed by the advantaged. Caste, class, status, gender, ethnicity, age and sexuality fall into this category. In India the caste of 'untouchables' continues to be subjected to systematic structural violence. Women opposing discrimination have, around the world, been widely and brutally humiliated, even in public. Sometimes events can trigger individual and collective reflexivity and resistance, as when the horrid rape of an Indian medical student by five men led to a public outcry against the structured gendering of justice.

But who actually has agency in lobbying for the needy? And how can advocates cure their own illness of representing the needy when they do so by even unwillingly advancing their own privilege? It is a profound problem that critics of the aid industry have made for years. [109] Advocates do not see their own obsession with the bright lights as itself an illness. One definition of difference is "inequality". "Excellence" is also a relative term based on inequality; so is "success": so is "equality" itself for that matter.

Recognizing who does and does not have agency also means recognizing that advocates by definition have it. Recognizing that structural violence is a knock-on effect of our blindness to inequality in all its forms at least sensitizes us to the need for simple humility when we have privilege, and the importance of cultural trust when we don't.

iv. Transforming Economies of Health

In that cultures are "conventional understandings, manifest in act and artefact" [3] global health priorities (whether they are those marshalled by the financially greedy, or the ones favoured by human rights activists) are also cultural; for medical hegemony is itself an artefact and outcome of cultural practices. Because they are cultural, however, in no way should incline us to find them less "real". Rather, they are more so; for culture and value are anthropologically speaking wholly inseparable. If we fail to acknowledge this simple fact, we will fail to see how we apply equality in one setting (say, our views of democracy) and thrive on inequality in another (for instance, when we strive for excellence in the face of mediocrity). It is not inequality, therefore, that is at issue here; it is how we describe and understand our agency and

advantage when it comes to managing the unequal opportunities that life always places before us.

Though being self-aware is undoubtedly one of life's most difficult tasks, this much is self-evident: culture mediates between agency and the structures that provide or limit wellbeing, healing, and health. Insofar as there is tension between the structurally advantaged and structurally disadvantaged, culture provides the pertinent sites and the relevant narratives for both contestation and (sometimes) human conflict. [109] This observation we believe is of critical importance to health, because it alerts us to the cultural dimensions of our shared moral choices. We do not mean by this that morality is relative; but morality is, indisputably, always expressed in relative terms. Narratives tied to vested interests comprise functional ideologies, whether those be based on views we hold to be onerous or morally upright.

In his work on French asylum policies and immigration, physician-anthropologist, Fassin, describes precisely this moral variation--how the lives and sufferings of others are variably governed and altered by the tensions over time between repression and compassion. "Why," he asks, should there remain "in societies hostile to immigrants and lacking in concern for undesirable others . . . a sense of common humanity collectively expressed through attention paid to human needs and suffering?"[116]

How does a moral economy transform? Does the variation in a given moral economy also produces over time a kind of moral 'epidemiology'? Though the term used in this sense is ours not Fassin's, it does capture a critical point in his work: this being that it is far easier to claim the moral high ground of structural violence from the vantage of socio-economic and hegemonic stability and privilege than it is to acknowledge how humanitarian societies can become less humanitarian in the face of social stress—that is to say, how culturally generated are their purportedly universal human rights claims; for an attention to welfare and wellbeing is sadly negotiable even in states where the rights to health have been foundational.

Is a focus on structural violence, then, a 'red herring' when it comes to the actual lives of the socially disadvantaged? Writing on the state of refugees in contemporary France, Fassin cites a startling disjunction between humanitarian law and actual practice:

> In 2004, with 58,550 applications submitted, France became the industrialized country with the highest recorded number of requests for asylum, ahead of the United States, the United Kingdom, and Germany, which until then had been the top three countries for refugees. Yet, in the same year, the rate of acceptance of applications. . . reached its lowest level at 9.3%. Thus, if we count not the applications submitted but the actually granted refugee status, France. . . was far behind not only not only Pakistan, Iran, Tanzania, and Chad. . . but also Germany, the United States, and the United Kingdom. [116]

Indeed, Fassin is acerbic in his criticism: "As with other nations, France is more generous the less it has to bear the cost of its generosity". [116]

Unsurprisingly the most ubiquitous and influential ideologies are those promulgated by the structurally advantaged, whomsoever they may be in any given historical moment. Though the most powerful of ideologies are now global, even the best of intentions can go awry when we are not aware of the cultural nature of global priorities. This fragility of global agendas is evidenced not only in their moral variability, but in comparison to less proselytizing and dogmatic modes of thought and practice.

In Buddhism, for instance, the worst acts of evil are not those committed by 'criminals' as such, but by those who have had the privilege of learning and now use that knowledge inappropriately. Here, true enlightenment emerges from the transformation of embodied suffering.[168] Such a view brings into sharp focus the cultural suffering associated with the killing fields of Cambodia, Sri Lanka, and most recently Burma. To misuse the privilege of a good education, say, or to feel smug about the accumulation of personal capital, is far more sinful in this view than the behaviour of the overt miscreants (personal or structural) we identify and vilify.

Here, Bourdieu's well-known sociological notion of 'symbolic violence' moves the discussion beyond inequality by throwing light on the processes through which local values and responses to adversity are constructed. Allowing for significant variation in both degrees and in forms of agency, Bourdieu shows how an individual's 'habitus', or mind-set, extends to or limits the predisposition to act. This understanding of how self-motivating and self-sanctioning behaviours either move or limit human action has implications for health and health behaviour well beyond the material resources available to people.

Inequality, in other words, is only one (if the most crucial) part of what limits the capacity of individuals to control their own destinies. As a baseline it functions to establish what might constitute a more level playing field, but it also must still finds its voice within the framework of power promoted throughout medicine by which those who have voice are, even if unknowingly, positioned to appropriate the meaning and suffering of the vulnerable. [163]

v. Techniques of Erasure

In his work on oppression social theorist, Foucault, argued that the confinement of prisoners represented the highest form of dehumanization precisely because it eliminated the ability of the oppressed to attempt even the most basic eye-to-eye social contracts with those who imprisoned them. [169] His concern has direct implications for what a focus on structural violence may miss—namely, the effects of erasing other forms of meaning as well as our own capacity to apprehend those other forms. [170] While we reviewed this problem in our discussion of cultural

competency, it is worth remembering, as psychiatrist and anthropologist, Kirmeyer, writes, that

> for those others who come from far away, and especially for those escaping extremes of chaos and violence, experience is hard to come by and harder to convey. There may be elements of the random and arbitrary that fall outside the possibility of any conventional account, and challenge our need for order and explanation. [136]

Kirmeyer's point is not that cultural awareness may be unachievable; far from it. Rather, he asks us to reflect on how what we find credible in narratives of suffering are defined for us by personal values that are never neutral. To provide proper assessment, practitioners must come to understand that sufferers of intense structural and political violence are often not going to follow convention by providing emotionally moving illness narratives that fulfil the expectations of their advocates.[170, 171] In some cases well-intentioned therapists attempting to evoke deep meaning are met with profound and simple silence. [172] Time and again, it is silence—what cannot easily be clinically revealed—that says so much about the limits of social engagement in moments of extreme suffering.

Evoking clinical responses, therefore, must be tempered by an awareness of what cannot be said. Even the most sensitive care providers may not only miss what is culturally critical, [46] but in favouring certain forms of empathic narrative also eliminate wholly what alternative idioms (behaviours at home, at work, in moments of heightened ritual engagement) assist the unwell in making themselves better. If we cannot become aware of the potential for another's normality being medicalised by our own--if we cannot see the cultural dimensions of our own values—we will surely miss most opportunities to realize the extent of our own clinical ignorance and to assist those most in need.[48]

Such unsubtle erasure of domains of meanings is particularly evidenced in the long-term effects of short-term clinical priorities; for here especially we miss the opportunity to learn from others how we might best engage their needs. When we assess our own practices only through measures that replicate systems of value we assume are universal, we not only limit the expression of other voices, but eliminate our awareness of having done so. In the UK, for instance, a much applauded 2010 NHS quality of care survey for antenatal maternity services demonstrated positive findings on good provider-patient communication in part made possible by increased use of online advice and related information services. But while the numbers of responses were high, the 25,488 women participants provided a response rate of just over 50%. [173]

Though many women did respond, with such a response rate, and with immigrants and minorities proportionately underrepresented amongst those who did respond, the question of widening health disparities, even in the face of apparent significant levels of satisfaction, remains real. With some hospital reporting high proportions of births to non-UK born women (as high as 76.4% in a single UK hospital trust), [173] one

can easily see how a false reliance on data can not only warp our views of the effectiveness of care, but directly erase the very people whose views such monitoring procedures were put in place to protect. How can we know what we are missing if we position ourselves only to listen to what we are prepared to hear?

As ethnographers know better than statisticians, you cannot measure what you cannot evidence: the empty survey form that comes back to school in the rucksack of the same vulnerable child it went home with cannot inform; but the study it is a part of can mislead. In such cases the fetishizing of data over basic human interaction—at home, with neighbours, in schools--contributes not only to our collective ignorance, but also to a widening of health disparities and the outright elimination of once-informative personal engagements that are now replaced by tools that sometimes only favour those who make those tools and can participate in their use. In rural USA, communities too poor to recruit the social capital to be designated as 'physician shortage' areas not only are not helped; they are completely erased. Here, obvious conditions of inequality are not only hidden: they emerge with a wholly wrong meaning.

For those of marginal social status (women, ethnic minorities, older citizens, gay, lesbian, and transgendered peoples), the risks of being culturally under-represented are real.[174] Norms can be internalised, allowing 'enacted stigma' (or shaming) and 'enacted deviance' (blaming) to be displaced or complemented by 'felt stigma' (self-shaming and a fear of being shamed) and 'felt deviance' (self-blaming and a fear of being blamed). While enacted stigma and deviance can and frequently do function to control and govern those with less voice, [175] felt stigma and deviance can function as forms of social control in which we police ourselves. Here, the personal responsibility to monitor and 'police' one's risk behaviours involves, for better or worse, a submission to one's own behavioural conditioning,[176,177,178,179] a colonisation of the patient's life-world and by implication a kind 'distorted communication'. [180] Today self-monitoring is necessary for health maintenance; but chronic stigma can lead to a sense that one is never actually 'well'.

The colonization of the patient's life world may be an inevitable outcome of the audit cultures we increasingly inhabit; but what may be more challenging is our appreciating what knowledge about health and wellbeing is lost when global processes colonize local ones. This kind of colonization occurs, for instance, concretely when we engage with new and emerging 'bionic' technologies. Every time we book a flight, bank electronically, or fill out a hospital form online we not only engage in acts that are meant to make otherwise onerous tasks more convenient; we also accept the responsibility of carrying out work for the institutions that make these demands upon us.

Our lives are, in other words, constantly being defined and redefined by information systems that set the terms through which our wellbeing must be negotiated. At the same time, the easy flow of information today shifts responsibility for care to the individual who can now be blamed for not accessing what is on offer when he or she may well be incapable of participating in such processes.

To understand how violence is overtly expressed and covertly imbedded, on the ground research must be supported to identify not only those who express the effects of vulnerability, but those whose voices have been wholly eliminated.

4. Rethinking Cultures of Care

i. Culture and Knowledge

If health outcomes can be enhanced and cost savings realized by allowing caregivers the time to engage with the unwell and to provide them with better avenues for integration into care communities, the question must rightly be asked why more resources have not been invested worldwide in supporting the development of integrated communities of care that function between biomedical settings and the diverse needs of multicultural groups.

Though explanations for this absence are complex and not easily generalizable, the increased medicalization of clinical care throughout the twentieth century has had a profound impact on the ability of empathy to emerge in clinical settings. Here, there is an implicit and unquestioned assumption within biomedicine that needs challenging: doctors have knowledge; patients have beliefs. The latter group is, of course, implicitly and sometimes explicitly identified as the source responsible for corrupting medical knowledge; as such it includes more broadly members of cultures that reframe, translate, or simply do not or cannot participate in medical science. Those left out make up the vast majority of the world's citizens for whom biomedical care is unaffordable or unavailable—who depend upon human care for health, instead of healthcare. At stake here are not only biomedical needs, but another contentious and unsettling matter: the epistemological status of rational knowledge systems compared with beliefs held by patients that are culturally influenced.[181, 182]

Yet, social scientists have established a framework and a body of knowledge through which biomedical claims are also shown to be shaped by a range of political, economic, and cultural forces. [35,125,183,184] Evidence-based medicine (EBM) and practice (EBP) are, we now recognize, not wholly neutral, objective bodies of knowledge. They are products of specific contexts, and anchored within specific historical frameworks, just as beliefs and practices are embedded within traditional cosmologies. [47,64,185] Medical knowledge is always changing; though its naiveté is only apparent retrospectively, it is nonetheless made apparent. Otherwise, we would not recognize progress.

Vested interests—including the pharmaceutical industry, scientific laboratories, bio-medical status, and cultural identities of researchers and their institutions—determine research questions, study design, sampling techniques, research instruments, data analyses, and interpretation. [186,187] Above all, they not only shape illness categories; [188,189] they constitute cultural frameworks in themselves. They have their own values, conflicts of interests, dynamics of power, and methods of knowledge production, which can differ significantly from those of other cultures,

sets of values, and the community needs we would hope them to serve. How community health gets regenerated in a climate of widespread fiscal and ideological retrenchment presents, therefore, one of the biggest hurdles to contemporary healthcare. Here, the constant reminder of what cannot be afforded is perhaps the greatest obstacle to thinking about what can be possible.

ii. Community Culture and Health

Social scientists rightly argue for a tolerance of worldviews. But to do so without acknowledging perceived vulnerabilities in both majority and minority groups, and the effects of retrenchment on clinical cooperation, is foolhardy. Tolerance is rarely sustainable in insecure social settings where consensus, social agreement, and basic trust are at risk. In difficult times the number of trusting relationships a person can manage drops dramatically when compared to what is otherwise tolerable under more favourable conditions of prosperity and social security.[190] At the same time, austerity can have unanticipated outcomes—often widely destroying community networks, but also on occasion generating innovation. However, the costs of such innovation are high, as many less formal and more fragile networks of support disintegrate when systems of social support collapse or are withdrawn.

In difficult times, those who survive destabilization and successfully transform their practices and ways of thinking are few, as they must often innovate under duress. Though necessity may, indeed, be the mother of invention, the problem with *enforced innovation* is that it often comes at ethical and moral costs that are wholly unacceptable. An important question, therefore, emerges regarding what can be learned from the past at the level of regenerating community, and regenerating cultures of care in particular; because simply forcing cutbacks to induce innovation is wrong on many levels, most of which are ethical. Might one, then, learn from the past instead of resorting to draconian political oscillations that may well introduce change, but that undo or even destroy fragile systems of existing trust in the name of hoped-for progress?

As it turns out, there has been substantial research in the area of health community building, not the least being the circumstances that gave rise to the world's single largest healthcare provider, the UK's National Health Service. Surprisingly, its origins were neither national nor English. In fact, the basic structure of the NHS was adopted in 1948 from a plan begun in Scotland in 1913 (and set out formally in 1936) to attend to the neglected health needs of rural poor in the Scottish Highland and Islands following the longstanding social collapse caused by the Highland Clearances of the 18th and 19th centuries.[191] A system of health care for all was, in other words, an innovation that grew out of a brutal disaster that led to a regional community health innovation.

There is a useful lesson to be learned from this history: what made the Scottish plan work was that it was neither wholly local nor wholly national. It neither forced communities to deal on their own with a redistribution of scarce national resources—dividing dwindling assets and requiring communities to get on with

things; nor did it expect members of rural and remote communities to see their futures as nonlocal—as dependent on the draw of urban areas where better services and opportunities for advancements would be supported in the name of excellence.[192]

In fact, what made the system work (not only in urban settings, but for the most isolated areas of the UK) was, first, that it embedded and incentivised healthcare providers sufficiently to allow otherwise fragile communities to re-emerge and survive; second, it elevated the status of rural doctors through its inducement practitioners scheme; and third it allowed doctors to become advocates for the communities they served. These are baseline strategies that we could do well to emulate today, and that we must devote serious resources to understand better.

The initiative worked; and it worked because its designers recognized that care is a person-to-person exchange that can be disrupted easily when community is eroded or when advocates' loyalties and aspirations are in conflict. The evidence, for instance, on removing Alzheimer's patients from home to care-home dramatically demonstrates this truism: disorientation is a significant risk factor for vulnerable peoples, and also for migrants of all persuasions, regardless of health status.[193, 194] The importance of understanding the reasons why the NHS initiative worked cannot be overstated: one hundred years on those same Scottish communities still place having a primary care doctor at the centre of what they define as key in making a community viable. [195]

It is not, in other words, clinical care alone that sustains health; it is clinical care embedded in relationships of social meaning—that is, not only in community in a demographic sense, but in community as it facilitates face-to-face consensus about suffering, tolerance, altruism, and goodwill. Here, success demands complex social skills that are not well replaced through technical innovations in communication.[196] Socially generated human wellbeing is the other half of clinical care that makes or breaks a population's willingness to shoulder social burdens and to emerge with dignity and respect for having done so. Human wellbeing is if anything about sustainability, trust, and continuity. It is not an 'indicator' to be measured economically, even though public trust is itself measurable. [197] Social security cannot be generated in the absence of social trust, unless security is defined only as the economic advantage over others, in which case collective wellbeing is impossible.

Because health business cultures can be made up of very well-intentioned people, they do frequently sponsor highly useful innovations that are in the public interest, just so long as they can maintain a strong financial base. The problem with such a strategy for public wellbeing is that they may also be sued by their shareholders if they do not put legitimately accrued profit-making ahead of altruism, no matter how responsible their social ratings may be. While profit motives can, therefore, incite productivity, they cannot induce altruism; for competitive gain is never a gain without another's loss.[190] Otherwise gain is not competitive. And where illness is concerned, so much is just that—a fear of loss that may be irreversible.

Illness needs are in this sense not commodities; they are not easily subject to replacement and compensation, which is why law courts remain so busy dealing with health neglect. If public-private partnerships are to serve communities, new ways of establishing trust must be developed that are not mediated by the financial demands of shareholders, or by the prestige cultures that policymakers and global health leaders themselves subscribe to.

When needs are defined as marketable provisions, businesses that serve the needy will and do act in predatory ways, which is why today one can legitimately question the public health goals of healthcare, in spite of support for care commissions and other overseeing bodies. In short, what we learn from the history of the NHS is that, if communities of care are to re-emerge, patients need advocates—non-conflicted advocates—as much as they need medicines. This need is no more clearly evidenced that in wellbeing and how it is assessed and understood. Because of this inescapable fact, the future of health can only be advanced through a complete reassessment of the role of culture in making all of us better.

The importance of culture for the future of health lies, then, not only in policy implementation, but also in its formation. [198,199] The activities of those providing services have a profound impact on delivery. Indeed, service activities, routines and decisions "effectively become the public policies they carry out". [200] Health workers have a significant degree of discretion over the allocation of rewards and sanctions; without this discretion, the system would collapse under the weight of its own rigidity. At the same time, overworked, under-remunerated, and under-trained providers can render universal political declarations on the future of health empty, as we see when so many global achievement goals come and go unfulfilled.

Where are such issues being acknowledged? Recent developments in culturally informed biomedical approaches, such as global mental health movement and the 10/90 gap of the Global Forum of Health Research (the 10% research expenditure on the poorest 90% of need), highlight the danger of capitalist societies and market economies imposing a fiscally-driven, biomedical template on understanding and treating illness. [201] Recognising that different societies and disciplines have vastly divergent ways of knowing and of managing health and illness now needs to be embedded in medical education worldwide. [202,203] The same concern applies to health research and the devaluing of work carried out in locations that are either perceived, or actually are, less regulated.[204] Researchers and policymakers often fail to recognise or actively prevent the assimilation of practices and findings from other countries precisely because both prejudices and practices are largely cultural in nature. [205,206,207,208]

Finally, engaging with patients and communities, and assessing the local moral worlds of human suffering, require an examination of the ways in which knowing is culturally negotiated in clinical practice.[46, 209,210] This core clinical activity has so far eluded EBM and EBP, yet can be effectively addressed by social science methodologies. Until a nuanced analysis of clinical encounters are better

understood, addressing human and financial resources to scale up service delivery models will continue to fail in its objectives. [211]

iii. Migration and Communities of Care

When global forces make possible and/or necessitate migration from one culture to another, destabilization produces both opportunities and vulnerabilities. On the one hand we see that the health outcomes of migrants more than explain the urge to migrate. Bangladeshi women, for instance, can increase life expectancy by a decade or more by migrating to Europe. [212] And provided they migrate into families and stable communities, Cypriot migrants can expect to live as long and as healthily as those who stay put in times of peace. [213,214]

But vulnerability increases exponentially when family networks and the heritage they embody cannot also migrate. This common fact needs to be accounted for, especially in global environments where new alliances must be rapidly made. Recruiting allies in unstable moments is critical to survival for migrators, especially when the behaviours, rituals, and artefacts that manifest and embody cultural values disappear. This is where heritage is more than a polite celebration of a sense of belonging. As a stabilizing device, heritage acts as a lever for the public self-definition and acknowledgment of a culture or constituent groups within a state. [215] It is widely accepted that heritage, then, is an important facet of society in providing cultural references both for national populations and local communities. [216]

In spite of this fact, governments are by and large unwilling to place a high policy priority on heritage over other areas deemed to represent more immediate and concrete needs. This oversight, we argue, represents a high-order mistake. That governments appear reluctant to prioritize cultural heritage is also evidenced in the fact that the recent UK Wellbeing Index, inaugurated to provide an alternative measure of wellbeing to traditional economic measures, omitted cultural heritage as a measurement domain. One argument defending this recalcitrance is that the social benefits of culture and heritage are by nature, tacit, and are consequently complex to quantify; without the ability to provide a 'hard' measure of impact, culture and heritage are dismissed in favour of initiatives that policymakers believe will yield more tangible results. [217]

Notwithstanding the robust and longstanding evidence (some marshalled in this Report) regarding the impact of cultural participation on sense of self-worth and stability, policymakers continue to cut cultural programmes that enhance perceptions of equality among those who otherwise feel unequal. Cuypers et al conducted a large population study in Norway involving over 50,000 adult participants to assess the role of cultural activities on perceptions of health, anxiety, depression and satisfaction with life. [218] Results showed that participation in creative cultural activities can be directly correlated with good health, satisfaction with life, and low anxiety and depression, even when the data was adjusted for confounding factors.

There are numerous other examples that provide quantitative and qualitative evidence for the impact of engagement with culture on levelling health inequalities. [219,220,221] On-going health reforms that shift responsibility to local communities will change the way health and social care services are delivered in the future.[222, 223] New models involve a shift from 'cure' to 'prevention', encouraging local communities and people to take collective responsibility for their environments and their capacities to affect public health. Such reforms will require a multi-agency approach with an increased reliance on third sector organizations that can assist communities where governments fall short, especially when hardship involves oppression, psychiatric trauma, and irregular migration.[224,225]

Research into diverse health views of speakers of non-native languages has also been instrumental in furthering our understanding of the wide range of needs around the globe. What such research seeks to forestall is the latent tendency to medicalize ethnic groups on the mistaken assumption that because they fare less well they are somehow less willing to comply with and adhere to treatment regimens. [226,227] There is significant scope for further research into these areas, particularly through studies that critically explore how ethnicity and language proficiency can be wrongly held responsible for clinical nonadherence.[228] This need is especially apparent when healthcare providers consult in multi-ethnic communities where the need for translation is essential.[229,230]

Language mediates most experiences of health care services for patients [231]. These include not only face-to-face consultations with health care practitioners, but the accessing of language-specific medical leaflets, health-related television programmes, and, increasingly, health advice on diagnostic websites and regulated and unregulated discussions online. However, intercultural health communication is not only about language translation; it is about situated beliefs and practices regarding causation and efficacy, local views on what constitutes effective provision, and attitudes about agency and advocacy. [232] It is, in other words, specifically about understanding communities of care and how they function at the local level to ameliorate the uptake and overuse of expensive services. In one North London community studied for this Report more than 50% of the community health organizations functioning in 2010 shut down as the result of government withdrawal of support for their services, while emergency room admission for primary care rose dramatically, including some 20% of admissions for which the patient could name no primary care provider as an alternative care pathway. Such are the real knock-on effects of ignoring the social needs of patients; and who is quantifying the real loss in both social and financial terms, let alone in terms of mortality and morbidity?

But health and culture not only deserve attention from the point of view of patients and health care professionals; there is also a critical need to understand the impact on care communities of increasingly diverse non-medical staff, including social workers, receptionists, telephone and internet respondents, and care administrators who function as service gatekeepers. Today any and all of these providers may participate in their own professional cultures that are as, or even more diverse than,

the patients and communities they serve. In other words, the responsibility for advancing cultural awareness in health practice should not be borne solely by those who deliver direct care; nor is responsibility be to be seen as a 'community issue' and therefore non-clinical.

A renewed focus on delivery cultures in medicine--on structural awareness and its affects—will help us conceptualize the entire therapeutic pathway, including not only the physician's practices and clinical techniques, but also the patient and the patient's socio-cultural values and patterns of behaviour.[233,234]These are social science skills much in need of legitimate support. The socially embedded patient and his or her culturally-mediated behaviours are the other half of the healthcare delivery equation—perhaps much more than half. Health resource allocation must be informed by an awareness of how different cultures of care variably enhance health and wellbeing, and how diverse social communities interact with systems of caregiving. Decisions about health behaviours must be made by all of us in light of life goals and what we consider feasible.

iv. The 'Danish' Question

One might be tempted, given the great names that have applauded inequality as a generator of invention and innovation, to accept and leave the argument that anti-welfare cultures encourage the successes of a few (even if at the expense of the many)—whether success is measured in financial, intellectual, or creative terms. But there is an alternate anthropological view to such a position which we have argued herein: this being that societies in which local concerns are not widely embraced, and in which wider interests are at odds with the exigencies of local cultural values, are dysfunctional.

Creative or destructive though inequality may be in galvanizing individual initiative, its presence both forces citizens into new alliances and affiliations that are viewed by them as more important than their otherwise national policy-level affiliations, and distracts them from the idea that socio-political involvement is of any consequence. One only has to look at levels of public disinterest in political processes to make the point that political concerns are increasingly only of meaning when citizens feel provoked by the impact of those processes on their individual lives.

The point of considering the 'sick society' and the role of states in building base-line welfare has not been to ask about a state's responsibility for supporting cultural difference at all cost; for these will vary--as social scientists understood long ago—on a society's capacity to feel either 'healthy' or 'sick', on its priorities regarding social innovation and social stability. What emerges, rather, from a consideration of obstacles to building communities of care is whether we might better consider different socio-economic estates as new kinds of cultures—as "conventional understandings, manifest in act and artefact".[3]

The contemporary rise in social inequalities —visible in the flow of resources away from local communities and national governments that might otherwise have used

them to support social welfare— is undeniable. Whether or not we agree that disintegration is a key indicator of a 'sick society', such new affiliations clearly represent exclusive, hierarchical cultural affiliations that transcend the traditional frameworks of nation states—what cultural theorist Umberto Eco has labelled for its condition of extreme inequality, the New Middle Ages. Here financial inequity is only a sign of a more important rift; for the hierarchical separations that constitute societal un-health are precisely those that strive to build often exclusive bonds that cannot be controlled by traditional political institutions. As formal institutions weaken under the burden of resources now lost 'off-shore', we witness the real erosion of nations' abilities to chart their health futures.

Panel 6. Gambling on Community

Considered in this manner, the comfortable academic, parliamentarian, or international relief administrator, may share in real terms more with his politically opposed but economically equal neighbours—with the unlike-minded professionals with whom he affiliates as a matter of daily living—than he does with the needy cohorts to which his moral persuasions sentimentally attach him. The CEO of a major corporation may find more in common with the CEO of a major charity than either one does with the poor he or she employs or represents. One need only look at residency patterns in major capitals to witness the florescence of such new cultural affiliations across ideologies and moral persuasions.[237]
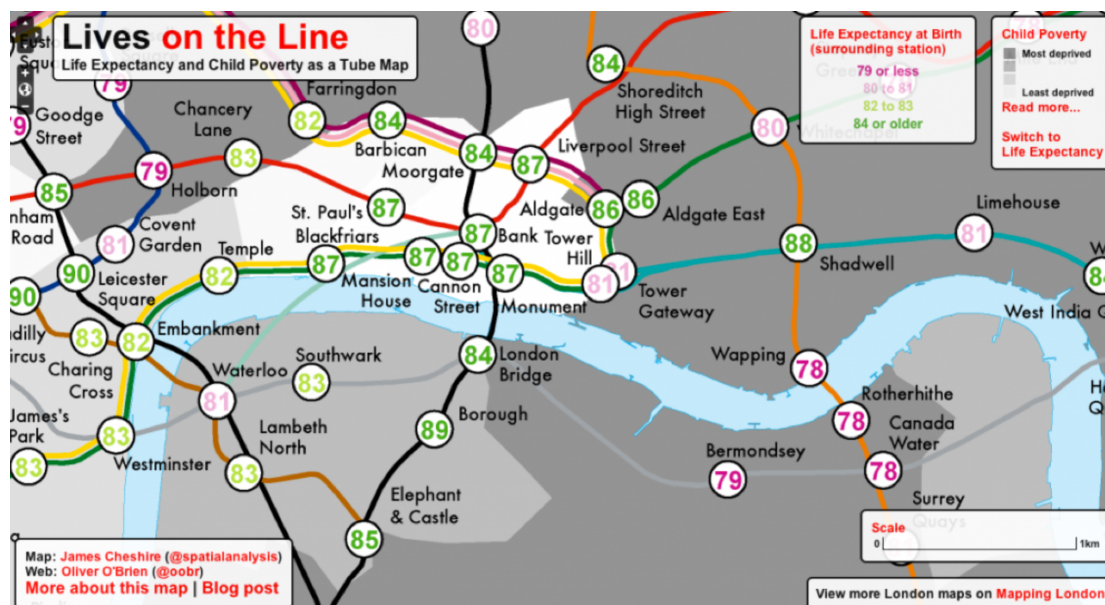

Figure 4. Life Expectancy and Child Poverty as a Tube Map. Life expectancy can decrease by as much as twenty years as one moves from 'off-shore' central London to it peripheries. [238]

The point being that, because these otherwise socio-economic affiliations occur in the face of weakened national institutions, they emerge less as only socio-economic. Rather, they emerge as deep indicators of new cultural alliances that may not be in the wellbeing interests of populations at large—hence the more than metaphorical

comparison with the Middle Ages. This Commission argues, therefore, for a need to realign socio-economic indicators—to see them less as differences to be levelled, than as signals for the need to rethink the autonomous and often unhealthy cultures of care they endorse.

Why make this conceptual shift? Why rethink health and wellbeing inequality as the devolution of a 'sick society' into self-centred sub-cultures of exclusion? The reason is as basic as it is simple: doing so allows us to see how hierarchy becomes culturally reified as an end in itself when we abandon social welfare in favour of new alliances that subjugate outstanding socio-political processes—new cultures of prestige and prestige imitation.

These alliances may be broadly socio-economic (as when the rich contract amongst themselves to become richer); they may be religious (as when beliefs trump national human rights codes); they may be institutional (as when health providers and academics congregate in centres of excellence); or they may be highly localized (as when America Tea Party chapters inveigh against most anything 'foreign'). In all cases, what emerges under conditions of cultural exclusion and instability—be they caused by grotesque financial inequality, social ambivalence, or natural or human disaster—are, for better or worse, realignments, new forms of social contract. Indeed, even in the happiest of nations, the importance of social contract in wellbeing is notable.

Denmark provides a stunning case, frequently figuring in health and happiness indicators, and openly valuing basic caring. But the reason for the Danes' wellbeing may be found less at the level of public health or individual happiness than in the quality of interpersonal relationships expressed in values such as trust and love— that is, in the ability of people to create new kinds of social contract with those they socialize with, and to believe that they will not be punished by forsaking those relations in favour of more abstract global concerns considered "more important" among the good and great.

There is hard evidence for this line of reasoning. While most Europeans notably rate health as central to their experience of happiness, Denmark, Europe's presumably "happiest" country, differs. "In almost all the European Union countries, [health] is seen as the most important in relation to respondents' notion of happiness. Denmark is the only country in which health did not obtain the highest score; with 61%, health is ranked in second place, just behind love (66%)". In fact, "Love was mentioned the most frequently in Scandinavia". [239]

According to Svendsen, Danish egalitarianism, social cohesion and human wellbeing rest on the experience of a high degree of social trust, which is not improved directly (in this established welfare state at least) by further policies or governmental surveillance. [240] The fact that Denmark chooses to redistribute its wealth more equally than many societies does, however, mean that its sense of community is, as Wilkinson and Pickett have clearly shown, "healthier". [241]

Unsurprisingly, tolerance also emerges as salient in such a social climate, even when Denmark embraces more firmly than other European countries an anti-alien policy promoted by a political swing to the right. As Rothstein argues, a high level of social trust has a relation to factors such as "tolerance toward minorities, participation in public life, and education, health and subjective wellbeing"—in short, towards the public and positive engagement of socio-cultural difference. [242] This conclusion is elsewhere corroborated: innovative work on clinical trials, for example, suggests that trust can be built into participant cohorts to the degree that incredibly low attrition rates are obtained when participants experience unanticipated social benefits, [243]even when they know they are part of the control arm receiving no clinical intervention. [244] Such studies need to be examined closely and immediately for indicators of how trust is socially generated amongst the unwell.

What the Danish data suggests is that welfare concerns may be as much the consequence of conditions of trust, as is wellbeing a consequence of social welfare. This interpretation is corroborated by the World Values Survey of Interpersonal Trust, which also has the Nordic countries at the top of the list (Figure 5). In Norway, where trust runs highest, the social convention of making informal contracts through person-to-person eye contact is widely recognized as a basic precept of social politeness: looking a person in the eyes when speaking is commonly understood as a foundation for trust-building. Trust cannot happen, in other words, unless people get out of their offices, cars, and homes —away from their computers and the continual presence of people like themselves—and create new contracts with those they otherwise consider 'different'. Trust building is, to push the point, a wholly social phenomenon, and those who feel that the future of health is online must look carefully at when and how such interventions induce mistrust.
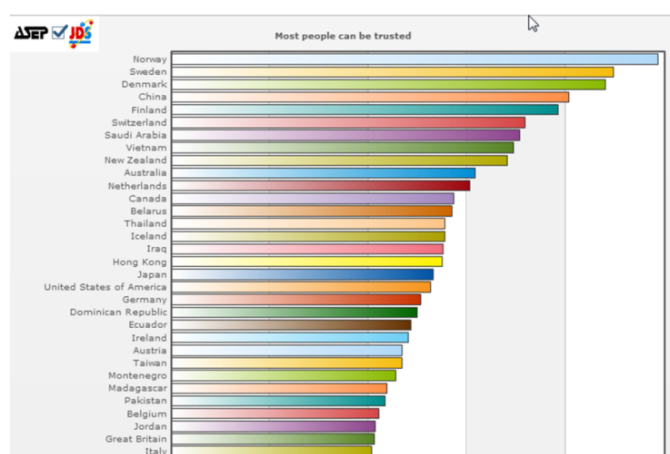

Figure 5. Interpersonal Trust. World Values Survey

Creating a culture that supports the formation of new meaningful relationships of trust can, of course, become for better or worse a target of government policymaking; though such values are not easily consolidated in the short term. A Eurobarometer study found that trust is also an essential prerequisite for an effective relationship between health practitioners and patients, as anthropologists

have observed in replacing the placebo effect with the meaning response as a core explanatory model for understanding social uncertainty.[245]

In spite of damaging policies regarding the limiting of clinical encounters, patients (and this Report) echo repeatedly the demonstrable fact that clinical social engagement—having the time necessary to develop trust—constitutes the single most important key to both effective clinical care and to making accurate diagnoses. A healthy and happy patient is also a more trusting citizen who develops multiple binding contracts with others over time, and with whatever welfare institutions may stand as the bearers of social security in difficult times. [246]Such a patient is invariably more tolerant, more understanding, and more willing to burden the consequences of personal choices.

Though the reality of this social need is made most visible when examining care-giving across cultures, what the social welfare evidence amply demonstrates is that the need for social trust in health is universal. Interpersonal trust is the central cultural value that enhances wellbeing and life satisfaction. Its value is measured not only in the ability of trusting societies to accommodate cultural diversity, but in the degree to which it forms the foundation on which individual freedoms can be explored and even quantified. Its value thus provides a visible measure not only of perceived wellness, but of where, when, and how diverse individuals build or fail to build strong relationships with health practitioners and with each other in the spaces wherein they live and work.

v. Conclusion: "Lives to be Valued" [157,158,247,248,249,250]

Health is a core human concern, even if it is not consciously considered or is valued only for instrumental reasons. Everyone wants to lead a fulfilled life that is free from disease, even if disease itself can be a catalyst for hope and even happiness.[251,206] We all value a disease- and disability-free state. Few patients care about disease indicators such a blood pressure or lung capacity in the abstract; it is only when they are connected in a recognisable way to themselves and their life goals that these measurements become significant.

Once ill, a sufferer cannot assist in his or her own curing unless possessing the capability, the opportunity, and the motivation to adjust affectively in an effort to create new forms of wellbeing[252]. Disease prevention is therefore inhibited by a key unwillingness to acknowledge the immanence of illness. Behind the commonplace statement that the purpose of healthcare is to 'improve health and eliminate disease' is a larger context in which prevention needs to be learned and in which creating (or restoring) wellness demands that the ill have options that are real to them, options that encourage them to live lives that they have reason to value.

Biomedical interventions often but not always provide the best way of dealing with the disadvantages that disease and disability create; they offer the prospect of bringing a person back to full health, rather than merely allowing that person to function despite ill-health or impairment. But understanding the affects of socio-

cultural processes on biological ones has been largely neglected and needs to become a primary research focus. Today, perhaps more than ever before, the mutual convergence of biological and social sciences creates new opportunities for revising our understanding of how socio-cultural factors influence biology, and not just the other way around. The changing parameters of specific areas of scientific research have resulted in recognizing the contingency and dynamic interactions of societies, cultures, and biological (immunological, epigenetic, neuro-scientific) processes.[253,254,255]

Proponents of the social model of disability argue that the disadvantages that individuals with impairments experience are due mainly to the way that social environments adjust to disability. For example, deafness was not necessarily a disadvantage in island North America a hundred years ago, where, as a result of several generations of congenital deafness, nearly everyone was able to communicate through sign language;[256] and the physically impaired have long argued that disability enhances the development of other skill sets[257,258]. Here, social and psycho-social factors underlie how one can live productively and creatively with what others might label a disadvantage. These changing areas of future research will by definition increasingly acknowledge not only the impact of biological processes on social ones, but of social processes on biological ones. Here we must recognize both the role of cultural awareness in providing a critical perspective *on* biomedicine and science, and the need for the social sciences to be more critically engaged *with* science.[259]

The failures of health provision are magnified by the cultural assumption that biomedical practices, being scientific and evidence-based—are value free, that somehow culture is something that scientists themselves do not have. If biomedical culture does not both acknowledge its own cultural bases and incorporate the relevance of culture in care pathways and decision-making, the on-going waste of public and private resources will continue to cripple health care delivery worldwide.

If the culture of biomedicine is only one of evidence-based practice, expectation of adherence, hierarchies of treatment, and disease aetiology, multiple barriers will go unrecognized, including the inability to afford medication, cultural and language differences, distrust of medical systems, past negative experiences, and stigma. If a patient's opportunity, motivation, and likelihood to adhere to medical instructions are not taken into account, poor outcomes will ensue, scarce resources will continue to be wasted, and diseases will proliferate, as when uneven adherence to antibiotic regimens produces treatment-resistance.[260] In a global context, the illnesses of the poor are now everyone's illnesses; though the privileged are less vulnerable, they are also increasingly less invulnerable. Behaviour change, therefore, is not simply a charge that can be placed against the poor and needy.

But behaviour change is only a part of the cultural picture. Like the socio-economic determinants of health, it is a major driver, but highly susceptible to cultural variation, to the health of a collective at large, and to the commensurate willingness of individuals to participate in collective action. When a society lacks the self-

reflection to assess candidly its own dysfunctional practices, it may use behaviour change strategies to induce conformity amongst populations that should not conform. Stasi East Germany provided many extreme examples of this, though the general problem is always present more subtly in societies in which proclaimed economic growth and optimism are not accompanied by collective trust. In such cases, it may be less that people need to change than that governments and prestige hierarchies do; for it escapes no one today that our collective problems are less about the absence of resources, than about our ability to control and utilize resources that now cannot be controlled. If our governmental cultures have themselves become inoperable and incapacitated, it is not only individuals who should be targeted to change their behaviours.

To re-capacitate a collective willingness to share disease burdens a new strategy for cultivating collective trust will be required. This project must by definition be cultural because there can be no way of knowing without an assessment of the health of a society if healthy groups produce social welfare or welfare states create healthy groups. New models will, therefore, emerge in unexpected ways and it is for this reason amongst so many others that an attention to the relationship between culture and health presents us with both our biggest challenges and our deepest hopes for humankind.

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