Rural health and the social costs of production

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Proposed research theme: Rural health and the social costs of production

- the way in which states of health are constructed and contested at a social level by different paths of accumulation, recognising that these paths include conditions that lie outside the direct circuit of economic growth, stagnation or decline, both reflecting and shaping these circuits

- three aspects of ill-health
  - how illness emerges from the ways in which people live in, work and transform their natural environment, including conditions of air, soil, and water;
  - how illness emerges from nutritional deficits related to but not simply reflecting income deprivation;
  - how illness emerges from the organisation of the labour process itself.

- Particular focus on the social costs of rural production
  - Because in both colonial and post-colonial periods the social costs of production have been particularly left on the shoulders of rural people for both political and economic reasons
  - Because questions of rural/urban poverty divergence in living standards have been too narrowly conceived as questions of income poverty at a household level

Source: Adapted from Lindelow et al 2004, Table 53, p. 82

Table 19 Percentage of users reporting access to alternative health care providers by residence		
Provider	**Rural**	**Urban**
Community health post	3.3	1.9
Hospital	18.6	70.5
Other health centre or post	34.7	67.7
Private for profit clinic	0.4	10.4
Nurse or doctor working from home	0.8	2.9
Outside services from facility staff	0.0	1.7
Religious organization or NGO	20.0	14.5
Traditional medical practitioner	76.4	51.2
Pharmacy outside facility	0.3	38.5
Market (that sells medicine)	5.0	12.2

[1] Source: Instituto Nacional de Estatística, 2004, Relatório Final do Inquérito aos Agregados Familiares Sobre Orçamento Familiar, 2002/03.

Table 13 Percentage of households needing and using health providers by province 2002-3

Province	access	need	Use	satisfaction
Niassa	29.7	11.8	9.2	67.2
Cabo Delgado	35.6	19.1	12.5	50.4
Nampula	35.5	20	11.4	66
Zambezia	21.5	17.6	11.4	50.6
Tete	26.9	17.5	10.5	60.1
Manica	28.1	11.8	9.2	67.5
Sofala	38.9	16.5	14.6	74.2
Inhambane	21.2	13.4	9.8	74.5
Gaza	54.7	11.6	9.8	71.9
Maputo Province	69.4	11.5	9.2	65.3
Maputo Cidade	75.2	10.6	8.9	54.1

Source WHO 2006 from DHS 2003

Child mortality (under 5) per 1000 by province 1997 and 2003

Province	**1997**	**2003**
Maputo Cidade	96.9	89.2
Maputo Province	146.5	108.1
Zambezia	183.1	122.9
Inhambane	192.7	149.1
Gaza	208	156.2
Manica	158.8	183.7
Tete	282.7	205.5
Sofala	241.6	205.7
Niassa	213.1	206
Nampula	319.1	219.5
Cabo Delgado	164.7	239.8

Practical problem
the space of advocacy and bargaining

- In negotiating with large entreprises, what more than paying taxes is to be demanded
- An issue in negotiation between local authorities and individuals/companies asking for land leases
- A question to be asked of government in public expenditure: the space of regulation, legislation and enforcement

Underlying premises

- Subverting the concept of social protection, which takes market outcomes as given and protects the vulnerable from them. Instead the concept of social production focuses on shape, extent and limits of the logic of the market
- Economic growth should not be an end in itself
  - Inequalities mediate the impact of growth
  - Growth is a means to socially defined objectives, including health, well-being, decent work, leisure etc
  - Accumulation reflects the organisation of non-commodified as well as commodified work

Narrowing the field of health

- Though illness and healing are interdependent, will focus on causes of illness rather than forms of treatment
- As causes of illness, will focus on those that are rooted in the organisation of production and thus the outcome of the ways humans shape their environments
- Will use Feierman´s concept of ´the social costs of production´

Context of Feierman's paper (1985)

- Debate over the impact of health care vs other forms of social and political change in health outcomes
  - McKeown and the 'health transition'
  - retreat from Alma-Ata
- Feierman's argument: Healers, when they are at their most effective, play a mediating role in society. They have the freedom, on occasion, to ally themselves with groups of lay people who want to improve the social conditions of health. By choosing allies and issues, they can improve states of health in the wider society.
- Meaning of title: *Struggles for Control: the social roots of health and healing in modern Africa*
  - *The micro-sociology of changing treatment of illness*
  - *The social context of disease*
  - *The healing occupations and their uses*

The Social Context of Disease

- Colonialism, population and health
  - Disputes historical evidence for constancy of high fertility and degree of mortality decline
- **S**ocial costs of production
  - the ones normally counted as factors of production AND
  - a wide range of costs which in some societies and at some times are counted as production costs, and at other times are borne by the state, or workers' families, or the entire population.

What are these wider social costs?

- the cost of making working conditions healthy,
- the cost of feeding workers and their families,
- The costs of maintaining retired workers
- The costs of either controlling or suffering the environmental effects of the production process

Conceptual difference from similar concepts

- **Difference from liberal theory (social cost)**
  - **specifying that the relevant linkages are between production and social costs;**
  - **specifying costs and benefits in terms of relevant social sub-groupings, e.g. class, gender, or the differentiation of rich and poor geographical regions (questions of inequality)**

- **Difference from Marxist theory (split between labour and labour power in capitalist economies and emphasis on social reproduction)**
  - **reproduction is something we intuitively think of as being private, the concern of a wife, a husband, and their larger circle of kin. Social costs of production does not have strong connotations tying it to a particular level (whether domestic, the level of a business enterprise, a local community, or the state). Second,**
  - **we easily forget that the assignment of costs to either the productive or the reproductive category is not objective or universal, but varies according to historical context. In the U.S. a cook who fries eggs in a restaurant is seen as producing, while one who fries eggs in a domestic kitchen is reproducing. In the U.S. the cost of protecting a worker from very high levels of exposure to lead is a productive cost; in South Africa the cost is assigned to the sphere of reproduction, for the worker is exposed and then, at a certain point, sent back to a rural home for relatives to support.**

Why I find the concept helpful

- **Emphasizes historical shaping of social costs of production**
  - In any given historical setting the particular distribution of social costs of production among workers, corporate capital, the state (*civil society groups)* and consumers has a certain stability. Some elements in the distribution seem to those in a society to be almost a part of the natural order, and not to be questioned
  - At each historical moment political conflicts bring into question some previous decisions on the distribution of social costs of production
- **Applies to wage and non-waged forms of production**
  - the fate of those employed for wages
  - peasant producers who may benefit from extension services, public education and health services, or who may be compelled to produce cash crops at price levels which lead to immiserization, and for people who happen by chance to live near fields sprayed by harmful pesticides
  - And households/places where there are both
- **Provides a frame for thinking about the inequalities of illness that goes beyond individual and household poverty**

  (see 'Question of Health and Inequality in Mozambique')

understanding health and illness requires time depth

4 Feierman case studies

- Schistosomiasis
  - Irrigation and the simplification of the eco-system
  - Unnecessary if costs of water and sanitation paid
- malaria
  - Commercial agriculture and spatial shifts in vector distribution
  - Enclave development, housing, silver-bullet spraying
- women's work and malnutrition
  - Crop regime changes, shifts in divisionof labour, seasonal labour peaks and seasonal hunger
- occupational health in southern Africa
  - Differential valuation of men´s and women´s labour and distribution of health services
  - Sorting of the fit and the non-fit

Designing research (tentatively)

- Areas of present negotiation
  - E.g. Recuperation of areas of irrigation schemes with debates over extent, crops, forms of ownership, ways of working
- Some historical depth should be possible
- Comparative study
  - with exposure to similar health problems
  - contrasting forms of using similar resources as core dimension of difference

  e.g. Outgrower schemes vs plantations
- Attention to observing collective as well as household inequalities (not just household surveys)

Practical Problems and the outputs of research

- If integration in in enduring public health systems rather than promises of isolated services and campaigns is to be negotiated with entreprises,
- and if government plans and policies are to be obliged to account for covering the social costs of production in strategies of accumulation,
- Then the issues must be clear enough to serve those who contest the ways the burden of the social costs of production are currently born in rural areas.