

DRAFT

Dynamic Model of Health

Commonwealth Working Group on
Gender Equality and Health Indicators
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Summary

In response to its terms of reference, the Working Group has developed a conceptual framework and methodology for the development of a set of gender equality and health indicators based on principles and processes derived from contemporary understandings of human health and how it is fostered, leading to a set of practical indicators whose relevance, applicability and robustness can be field tested in Commonwealth countries.

As an unanticipated but potentially very significant side effect to the Working Group's deliberations, the proposed framework could also improve the timeliness of information flows with respect to health generally. In doing so, it would improve the cost-effectiveness of health promotion services, of interventions for the prevention and treatment of ill health, e.g. the delivery of health services, and of information collection itself.

The document describes the process adopted by the Working Group, outlines the basic principles and processes underlying the conceptual framework and presents recommendations toward the development of a set of gender equality and health indicators. An appendix describes a practical instrument that the group has developed to facilitate the collection, dissemination and discussion of such indicators and to facilitate action on the linkages between gender equality and health.

Comments are invited. Please email them to Mary_Anne_Burke@hc-sc.gc.ca

Background

Tasked by the Commonwealth Secretariat to establish the framework and methodology for a set of practical gender equality and health indicators that could be applicable to any Commonwealth country, we began by examining available indicators models. Three broad model types emerged: a “morbidity/mortality” model, a “functional health model,” and a “values-based” model.

Many existing sets of indicators belong to the first type. This model begins with a narrow definition of health and a disease treatment approach. Built around “objective” measures of life expectancy, mortality and morbidity, it tends to perpetuate a “medical model” and thus fails to capture the totality of social and economic determinants of health.

A functional health model, such as the Health Utilities Index (HUI), is gaining widespread acceptance. In its methodology, the HUI recognises the importance of self-assessment and self-reporting. In acknowledging subjective criteria, the HUI does subtly go beyond the medical model of health based on strictly objective assessments of health status. The HUI provides a summary health score of an individual's overall health based on eight attributes of reported functional health status: vision, hearing, speech, mobility, dexterity (use of hands and fingers), cognition (memory and thinking), emotions and pain and discomfort. The HUI also builds in a measure of societal values concerning health status, by means of preference scores.

By definition, the HUI situates obstacles to health in the individual rather than the environment and equates disability with ill health. It is a linear model that regards people who are ill or have disabilities as burdens and as recipients of care, without considering their contributions. This is problematic as it leads to a devaluing and objectifying of people with disabilities as “other” and as inherently deficient and costly. By not serving people with disabilities well, the functional model reveals its inability to serve entire populations. If health indicators do not work at an overt level for one significant sector of the population, then they are not likely at a more profound and covert level, to work for the entire population.

A values-based model, as articulated by The Roeher Institute, begins with a broader, holistic definition of health, such as that adopted by the World Health Organisation (WHO), implicitly challenging the conventional distinction between “healthy” and “sick”. It begins with the principle that people are intrinsically “whole” or “healthy”, regardless of their reported functional health status. Its framework has three dimensions: self-determination, democratization, and equality.

Self-determination refers to capacity. It recognises that legal status and economic status affect individuals’ ability to make decisions affecting their lives. Diminished status in either realm, as is frequently the case for people with disabilities and for women, diminishes self-determination, with potential negative health outcomes.

Democratization refers to process. It recognises that health is not merely a characteristic possessed by individuals, but rather is relational. Well-being has a lot to do with how we are treated by others. To the degree that individuals feel vulnerable, stereotyped, objectified, and treated without dignity, democratization is not realised. This is an essential piece of the framework because it goes to the heart of protecting the valuable diversity and difference in society.

Equality refers to equality of outcomes, rather than equality of opportunity. It recognises that, without equality, individuals cannot enjoy their full human rights and their full potential to contribute to society and to benefit from the results of their contributions, leading to detrimental health outcomes.

At its heart, this model of health values both human rights and diversity. It sustains the notion that a healthy society is one in which the needs of individuals are met and their contributions are encouraged and recognised. This principle would provide for general population health needs as well as genuinely serving people with disabilities and other vulnerable groups in society. It embodies a holistic view of health that does not depend on a standard defined functional capacity. Rather, it upholds the value of diversity and challenges restrictive concepts and definitions. It recognises that the ability of every person to realise his or her unique potential, and the capacity of society to accommodate and honour that person's contribution, is the ultimate measure of health, both for the individual and for society.

Toward a Dynamic Model of Health

While recognising the shortcomings and limitations of some of the existing models, we acknowledge their particular strengths and contributions. In designing our own model to measure health and gender equality, we have built on these strengths and have attempted to avoid their limitations.

Like the values-based model, we have drawn on the WHO definition of health to define health as a state of complete physical, mental, spiritual and social well-being and not merely the absence of disease. Given the growing understanding, basically ecological in character, that personal health is a product not just of individuals themselves but of their relationship with their surrounding environments, persons should be encouraged to develop, directly and through their communities, values, practices and institutions and the conditions of their environments in such a way as to foster health. We assert that communities develop and become healthy through this dynamic process and that equality is a necessary precondition to full health.

We recognise that indicators are only generalisations that cannot really describe the uniqueness of the person. They are not an end in themselves but a strategy to draw attention to and to legitimise key factors and relationships that underpin the health of persons and communities.

Thus, we propose a model that is fully interactive and evolving. It is dynamic, developmental, flexible and emergent, like the values-based model. It is not a snapshot in time, or a fixed, final, definitive picture of health. It is not rigid, unidimensional, static, mechanical or reductionist. It is not defined by particular methodologies or data sources. It is not culture-bound nor does it perpetuate inequality and intolerance of difference. Consistent with the value that individuals are distinctive and make unique contributions, vibrant communities can assist in protecting and valuing differentiation and diversity, thus approaching full cost-accounting and thereby genuine progress. The model is grounded in human rights, recognises the importance of community and the basic dignity of the person. As such, our proposed model is built on a number of basic principles.

Basic Principles

- That persons are ineffable (undefinable in words) and thus cannot ever be fully defined even by themselves, let alone by others, nor, it follows, can their health ever be fully defined by themselves or others;
- That health itself is at heart a self-defined condition and hence that indicators of health that are self-determined must be held to be prior over objective and reductionist indicators by social scientists and others;
- That an exception to self-determined responsibility prevails where intervention has been collectively agreed to in consideration of public well-being consistent with personal self-determined well-being, e.g. infectious disease; second hand smoke; excessive burdens being imposed on collectively organized health care services; lack of certain types of information and means to achieve identified goals;
- That actualisation of these principles, in specifically identified circumstances, may require affirmative action initiatives with respect to the treatment of differences based on gender, race, ethnicity, country of origin, age, sexual orientation, or level of ability, etc., consistent with the principle that equality is a necessary precondition of health;
- That the primary locus of responsibility for personal health and for changing the circumstances that are not conducive to health rests with the person herself or himself, as an active agent personally and with others within a community; and
- That informed decision-making requires timely and user-costless access to good information.

Basic Processes

Communities and individuals must strive to create the conditions for fostering:

- Access to information for informed decision-making

Informed decision-making is dependant on having easy access to information from diverse sources, criteria on which to compare and assess that information, and credible sources with the expertise to assist in this process. The media are called to be partners in building communities that foster conditions for health.

- Supportive decision making

Individualised models of support that effectively enable community inclusion should be widely adopted and promoted. Central to these models are a focus on individualised planning and funding; status for individuals in the decision-making process affecting them; the creation of support networks to assist in decision-making and building community inter-connectedness; and back-up support accountable to individuals and networks to plan for and manage supports and

to deal with crises. Self determination is a capacity susceptible to development and contributes to health.

- Access to personal supports in all areas outlined by the determinants of health as proposed by Health Canada

The guiding principles for the provision of personal supports are accountability, flexibility and responsiveness in funding and support arrangements; and partnerships that lead to a restructuring of the demands on and responsibilities of government, to a strengthening of civil society, to healthier environments and ultimately to more inclusive and healthy communities and healthy individuals.

- Self-anchored indicators

Priority should be given to self-determined indicators anchored by and in the individual. Deriving from the principle of diversity and the uniqueness of each individual, indicators steer firmly away from attempts to classify and label people. Objective indicators should be used only where conditions warrant and are understood and agreed to by those whom they may affect, on the principle of “informed consent.” Such an approach protects not only the differently abled, but protects diversity within and among people and the different cultures of the Commonwealth. It also serves gender equality by allowing the expression of differences as the starting point, for example for health planning and for participation in health planning. Starting with self-anchored indicators helps to illuminate the principle of self-determination and the dynamics of the diverse factors that differentially affect the lives of women and men.

Recommendations

- That the basic principles and process outlined above be promulgated, discussed, affirmed and used; and
- That self-assessing health measurement instruments be developed having the following characteristics: Simple, metric, verbal and nonverbal, non culture-bound, inter-subjective, not fixed, changeable over time, able to be calibrated to small and large variations and sensitive differences. (For an illustration of such an instrument, see Appendix 1).

The WHO approach, on which we have drawn, distinguishes health *promotion*, the *prevention* of disease and ill health generally, and the *treatment* of disease and ill-health. With respect to health promotion, we encourage individuals, communities and nations to establish fora and communication channels for the promotion of health. With respect to prevention, it is our intent that our proposed model should open new channels for discussion so that communities can quickly identify incipient problems and generate immediate response. With respect to the treatment of disease, we believe it is necessary to rethink the delivery of services and that our approach should assist in the evaluation and improved effectiveness of existing health services.

Thus, in approaching the development of a set of gender equality and health indicators, we have endeavoured to apply consistently the prevailing understandings of human health and how it is best

fostered. Our approach is congruent with the basic principles and processes that emerged from these understandings of health and the balance of responsibility among individuals, communities and government. Among other things, we propose that our approach would improve the timeliness of information flows, thus improving the cost-effectiveness of health promotion services, intervention for the prevention and treatment of ill-health and of information collection itself.

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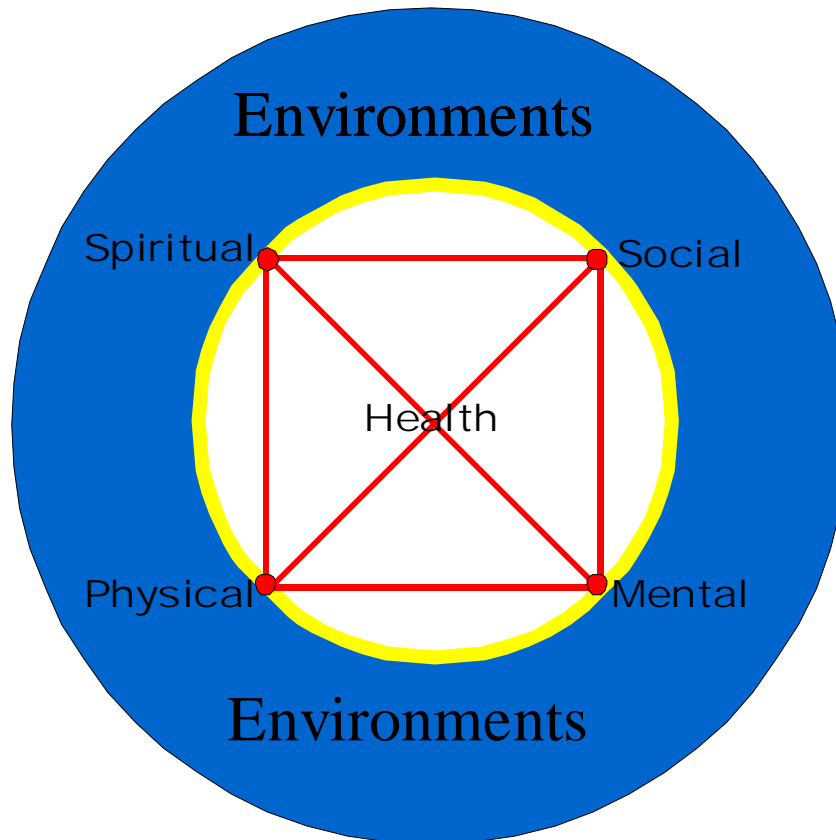
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Appendix

Dynamic Model of Health



Description of Model

Our proposed model of health continues to make clear that:

- persons are undefinable;
- health (as described by the inner circle of the model) cannot be fully defined;
- there are things we should not seek to measure and others that are not readily measurable; and that
- equality is a legitimate and universal issue with respect to health.

The model is multidimensional in nature, operating on many different planes akin to a gyroscope, rather than the flat instrument portrayed here. Each of the planes represents a different dimension of health: individual, family, community, region, state, or global community.

At the heart of the diagram is a flexible central area, representing health. Along the perimeter of this circular area are four nodes, representing the four domains of physical, mental, spiritual and social well-being. In keeping with our holistic definition of health, we have not assigned priority to any node over another. Full health depends on a balance among each of the four domains.

The nodes are connected to each other by elastic cords calibrated to permit individuals, families, communities and states to record their self-assessed health status in each of the four domains, and for these to be measured and compared. The shape of the circle becomes distorted, if ill health in any of the four domains is not counterbalanced by a countervailing support in one or more of the other domains. For example, individuals with physical disabilities who have their needs fully accommodated by additional supports in the physical, social, spiritual and mental domains may report a state of complete health. Within the model, this would lead to a strengthening of the force exerted by the cords, such that equilibrium would be maintained in the central area.

Encompassing and supporting the multidimensional model are the various environments in which individuals, families, communities and states play out their lives. Thus, the blue outer circle represents the physical, cultural, economic, social, spiritual, and other environments that affect the physical, mental, spiritual and social well-being of individuals, families, communities and states. When these environments are detrimental to health, the blue circle compresses and puts pressure on the rest of the model, leading to disequilibrium.

The model is dynamic, just as the elastic cords between the four domains can adjust to achieve equilibrium, so too can the different planes of the model. Thus, if an individual with ill health is well supported by a healthy family, community and state within health environments, the model can maintain stability. Conversely, unhealthy families, communities, environments, states and global community can destabilise the model and lead to ill health for the individual.

The proposed model may also have predictive value -- by locating particular vectors (created by imbalanced combinations of the four domains) in which particular individuals are prone to move as a result of the forces operating on an individual, and thereby locating potential avenues of prevention when at-risk situations are indicated by the model. For example, an indicated lack of social support suggests the initiation of substitutes such as in-home care by the state.

Such an instrument could be applied in practice at a variety of levels, e.g. as a basis for sample surveys by health or statistical agencies, as a means by which communities can self-assess the level of community health, as an instrument for small group discussion or to facilitate community development and as a device for individuals to self-assess their own health over time.

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