

## 5 why society is making us sick



Tash Gordon and Becc Griffiths

### **your health, whose responsibility?**

Your Health. Is it something you take for granted, feel helpless to improve or something you feel you understand and take responsibility for? Our health is determined by many factors and we want to explore these and talk about how we can affect them. Crucial to this is how our society functions. While we agree that our industrialised capitalist societies have brought some enormous improvements in health, we also need to look at how they constrain it and how a centralised and corporate influenced medical profession has reduced our ability to manage our own health. This chapter is about how we need to change society and our relations with others in order to improve our health. As we discuss, societies that are the most equal, not the wealthiest, are the healthiest. It is possible to act for ourselves to improve our health and that of others, and this chapter and the next provide some pointers.

What guarantees our health is complex and difficult to define. We have chosen a broad view of health which encompasses our physical, mental and social well-being. Good health in all these areas is the basis of our lives and therefore of paramount importance. Illness undermines our ability to live as we wish and our ability to challenge the conditions that make us sick. Our immediate environment is the major factor determining our health. Put simply, genetic make-up dictates a number of rare conditions and a predisposition to many more common diseases, but the world around us plays a far larger role. Health is affected by material conditions, including where we work and what we eat, but there are also, largely ignored, social conditions: how vulnerable or oppressed we are, who we have to support us, the amount of conflict we face, the fear we live with, how powerless or empowered we feel, the amount of control we have in our lives, and how safe we are from violence. The greater our control over our own lives, the more opportunities there are to improve our health.

The motivation and interest for us to write this chapter comes from both our personal and professional experiences. One of the authors (Tash Gordon) is an inner city GP. Daily she confronts the impact society has on our health and is acutely aware of the way in which the personal situations of patients limit the action we can take to improve our health. A recent article in the British journal of GPs (family doctors) suggested GPs should stop being involved in social work issues like child abuse, homelessness and poverty, and stick to treating illness. This attitude results in a narrow definition of ill health; one far from the reality of the author's work where she might encourage a depressed patient to challenge the racial harassment that undermines her or for the author to write a letter supporting a patient's request for appropriate housing. The author's experience of working with autonomous health systems in Chiapas and Argentina taught her that the more involved people are in their health the more responsibility and action they take.



The other author (Beccs Griffiths) is part of a feminist health collective and is studying herbal medicine. She has participated in many workshops around women's health, reclaiming knowledge of our anatomies and menstrual cycles, pregnancy, abortion, breast health and more. She is also studying herbal medicine at university and as part of her studies she is involved in running a herbal clinic. She has been consistently shocked by how people are treated by doctors, how little they are listened to, how little information doctors want to know about their lives, how many drugs they have been put on that contradict each other, how many drugs they take without knowing why, and how little people know about their own bodies. These experiences have politicised her and made her realise how important it is to start learning and educating each other about our bodies and how to treat ourselves so we are less reliant on 'Western' medicine that treats the symptoms, not the causes.

## **society is sick**

If we want to create a healthier society we have to challenge the root causes of illness and disease. Acknowledging the type of society that we live in and how it impacts on our lives is an important start. We live in a society that is largely industrial, urban, based on hierarchy and capitalist in orientation, that is to say, an economic system that is reliant on the exploitation of people and natural resources for the accumulative wealth of a few. This has resulted in a society that prioritises profits and maintains power in the hands of a few, with little consideration of the quality of people's lives. This type of society impacts on our lives in many ways: the pressure to work, the

type and amount of work we have to do, how our time is valued, family structures, education systems, the quality of food we eat, pollution, alienation, poor housing and, of course, the medical system available to us.

This has different effects in different countries but ultimately most people are reliant on selling their time so that they can earn enough money to live. The negative health impacts vary in different parts of the world. In the global North, social isolation is detrimental to mental health (seen through the increasing number of suicide attempts by younger and younger people, and those suffering from depression and anxiety), whilst increasingly sedentary lifestyles, the relatively high cost of healthy food, and the availability of energy dense food is creating an obesity epidemic. The global South is used as a resource to keep the North rich, which undermines sustainable communities and traditional ways of life, replacing them with exploitative jobs, poor housing and loss of control over their lives. The control from the global North is increased through free trade agreements, structural adjustment programmes and military power, while war and the negative effects of climate change are a daily reality for many. All of these aspects of our globalised society are detrimental to health. As always, the poorest are most affected.

Our health depends not just on income but on a complex set of hierarchies, including wealth, race, class, gender, disability, age, sexuality and cultural background. Being black in the global North, for example, means you are more likely to be detained for compulsory psychiatric treatment and stay in hospital longer than white people and also more likely to be prescribed drugs or electroconvulsive therapy (ECT) rather than psychotherapy or counselling. If your sexuality challenges society's norms you will find that health professionals often have no training in issues specific to same sex relationships. As a woman you have a one in four lifetime chance of suffering domestic violence and its psychological and physical effects and you may find that people accept this as a normal part of a relationship. Class is a major factor: men in central Glasgow have an average life expectancy of 69.9 years, while it is 86.2 years for women in the Royal Borough of Kensington and Chelsea in London. Poor urban areas with high minority group populations within the USA have life expectancies and infant mortalities similar to those in Guatemala. Our position in these hierarchies affects our health through access to health care, education, good diet, housing and other opportunities that cumulatively mean poorer health and less time, energy or belief that this can change.

Living in a complex, urban, capitalist and hierarchical society in which many individuals and institutions have control over our lives creates stress. There is a proven link between levels of stress and the position we occupy in a social hierarchy – the lower the position, the higher the stress. The accumulative effect of this stress is

chronic anxiety, which has major impacts on health. This means that illness is not only caused by specific material situations, such as poor diet or damp housing, but can also be triggered by the anxiety caused by what we feel and think about our material and social circumstances (Wilkinson 2001). The alienation that develops because of hierarchies can impact on our health in terms of loneliness, depression and anxiety. All this not only leads to conditions such as high blood pressure, heart problems and lowered immunity, but also patterns of destructive behaviours like alcoholism, other addictions, violence and self-abuse. Similarly, studies have shown that it is not the richest of the developed countries that have the highest life expectancies, but those that have the most egalitarian distribution of income and less pronounced social hierarchies – an indication that if society is more equal people are more healthy (Wilkinson 1992).



#### **The loss of traditional medical knowledges**

From the fifteenth century in Western Europe there was a clear break away from the tradition of lay healers and communal medicine. This was mainly caused by the witch hunts that killed hundreds of thousands of women and lay healers over the next two centuries, resulting in the effective loss of their knowledge (Frederici 2004). The *Malleus Maleficarum*, written in 1484, was one of the first and most influential witch finder manuals, including specific torture techniques, and sparked a wave of manuals and witch trials. The church and the state in the form of the legal system and medical establishment had the power to declare who actually was a 'witch', and who carried out the trials and executions.

The suppression of lay healing and the rise of male professionals was not a natural process but an active takeover. The witch hunts specifically targeted female healers and especially midwives and those offering help with contraception. 'No-one does more harm to the Catholic Church than midwives' stated the *Malleus Maleficarum*. The Papal Bull of 1484 declares 'witches destroy the offspring of women... They hinder men from generating and women from conceiving.' In 1548 Reginald Scott wrote: 'At this day it is indifferent to say in the English tongue, "she is a witch or she is a wise woman"' (Thomas 1971). Many of the trials featured the topic of health. For example, if a woman cured someone, and that person became ill again, it was seen as witchcraft, and therefore a crime. The male healers, wise men and magicians were not killed and often ended up in positions of equal standing with the new physicians.

Historians have various explanations for this attack on women healers, which include physicians wiping out competition or covering up for incompetence or unexplained deaths – for example, they had little knowledge of cancer or strokes. A

deeper and more political explanation is a contestation over control of the body, and the female body in particular, and especially reproduction. This was due to a desire to control birth rates (adversely affected by women's knowledge of contraception and abortion) and more fundamentally to distance people from control over their bodies in parallel with new forms of discipline associated with capitalist work appearing over this same period (Frederici 2004).

After this bloody campaign of terror over two centuries had succeeded in effectively wiping out the networks of female lay healers, the poor population were faced with a choice between expensive, and largely unaffordable, trained physicians, magicians more specialised in finding spells than biology, or the demoted, untrained and unskilled neighbour. Women's ability to control their reproduction was hugely diminished as was the tradition of community based knowledge.

Western 'medicine' as we know it became established over this same period, with many of the men praised as the fathers of modern science deeply involved in the witch hunts. For example, Francis Bacon exposed the evil of witches alongside his more famous 'scientific rationality'. This new 'age of reason' included a ferocious attack on women's bodies (Ehrenreich and English 1973). Medicine grew in prestige as a secular science and a profession. By the fourteenth century there were licensing laws that prohibited all but university trained (and therefore male) doctors to practice, thereby providing a legal framework which complemented the physical persecution of lay healers.

As the training of male professionals developed and became the norm in the modern period, it ignored lay healer's knowledge built up over centuries which used empirical methods and had developed an extensive understanding of bones, muscles, herbs and drugs. As the largely male medical profession became dominant and their views were seen to be those of the 'expert', people were forced to become consumers of this type of medicine due to lack of alternatives. No attempt was made to share new modern medical knowledge such as anatomy and physiology, by the medical profession, and this discouraged people from developing an understanding of their own health and taking responsibility for it. As with many other aspects of the modern period, the irony was that despite massive progress in human understanding, this was limited to a small elite and actually fostered dependency and hierarchies.

However, it is fair to say that in many parts of the world, such as China or Africa, lay knowledge and practitioners faced less persecution and retained a more important role. Some of this has become part of Western medicine through the growing use of complementary therapies. Also the industrial era, while bringing many negative effects on health, also saw dramatic improvements in the management of sanitation and public health. Overall though, understanding the political construction of

this type of Western scientific medicine enables us to question expertise, reclaim knowledge of lay medicine and therefore begin to reconstruct a different type of health care.

### **Medicine – healing or creating disease?**

Over the last century the medical profession has played a greater role in everyday life, for example, in pain, sickness, pregnancy, childbirth, menopause and death. Fortunately medical training has improved over the years and doctors are both well trained in the health sciences and learn through real experiences with patients. This goes hand in hand with a welcome increase in evidence based treatments for a variety of conditions from meningitis to spinal injury. But with this normal bodily processes have been brought under professional medical scrutiny and control. Such medications of life is disempowering as it leads to a loss of knowledge and resources to care for oneself rather than sharing knowledge about how to deal with illness. For example, over the last two hundred years childbirth has become increasingly medicalised with high levels of caesarean sections and other medical interventions to speed up labour or give pain relief – actually making it harder for women to give birth (Vincent 2002). Births in hospitals are seen as the norm compared to home births despite no evidence of this being safer and plenty of evidence that women have less choice in their care (Johanson et al 2002).



More medical interventions can have negative impacts on health. Taking the example of the side effects of medications, in the UK over 6800 people die per year from adverse drug reactions and 6.5 per cent of all hospital admission are due to these reactions. Menopause, which is a natural and inevitable event, became seen as a disease of oestrogen deficiency to be treated with hormone replacement. Unfortunately, it took several years to produce evidence of its detrimental effects, such as increased rates of breast cancer. All medication has risks and benefits and clearly, while serious illnesses need effective treatment, the risk-benefit ratio must be carefully considered – for example, are hot flushes problematic enough to justify the increased risk of breast cancer? Taking a pill may seem the simple solution for depression but non pharmaceutical options like increasing exercise and support in mild depression may be safer and more appropriate.

### **Our interaction with our health**

We often only become aware of our health when we have a problem and then the path we take is to look to the medical profession for an answer. This can be problematic for a number of reasons.

First, although the majority of health experiences we have can be self-managed, with a small minority of illnesses a well trained health professional is desirable. There is nothing wrong with people accumulating large amounts of health knowledge, be they doctors, herbalists, witches, traditional healers. This is useful and necessary and has happened throughout history. Unfortunately doctors have been elevated to a position where their knowledge is respected the most – reflected in their social and economic position in society compared to any other health worker. This creates an imbalance in power which is often seen in the way doctors relate to their patients, as well as to other health workers.

Second, doctors are reluctant to investigate the social causes of illness. Within the health profession as a whole, there is insufficient examination of the political causes of ill health. Nor are the power relations acknowledged that are embedded in gender, class, race, caste, sexuality, age, ability, and their cumulative effect on people's bodies and lives. These power relations become institutionalised and are indeed replicated within the medical system. Research indicates that working-class women and black women are likely to receive less favourable treatment in hospitals than other social groups (Douglas 1992).

Third, there are general problems in relying on any 'professional' as their existence can discourage or prevent others from taking responsibility for their health. It is important to be able to challenge 'experts', question their evidence, motivations and judgements, and their influence over our lives and health care to ensure it is appropriate for us. In many health consultations there is an imbalance of power with people being told what to do with little discussion about whether they actually understood or not.

There is a large body of evidence that shows that health improves when there is a shared understanding of the problem and that the person and the health professional manage it together. Medicine is an art and finding the correct treatment requires an in-depth understanding of the individual. To ensure shared understanding the health professional must respect the person's autonomy (the most important medical ethical principle) and the patient must play an active role in their own care.

Many people, through negative health experiences, have become positively politicised. Unsatisfactory care might result in the pursuit of alternatives to mainstream health care methods or to questioning the causes of a health problem, leading to a better understanding of the power structures in society. People have repeatedly taken action to try and claim more control over factors affecting their health, realising that direct, autonomous input is often necessary to improve a detrimental social situation.

**More disease = more profit**

There are important criticisms to be levelled at the close ties between the medical profession and the pharmaceutical industry. Whose interest do they prioritise – that of the patient or the drug company? More money is invested in research and development of medications to be marketed in the global North where drugs can be sold at higher cost to more people. To increase market size pharmaceutical companies have been involved in changing and creating new definitions of diseases and then promoting these to both the medical profession and potential users of their treatments.

Everyday life occurrences are turned into medical problems, mild symptoms are portrayed as serious, and risks become diseases. This can make people obsessed with their health and disguise the social or political causes of health problems. These campaigns are normally linked with a drug company promoting a new product for the 'disease'. Recent examples of this include baldness, irritable bowel syndrome, social phobia, risk of osteoporosis and erectile dysfunction (Moynihan et al 2002). No doubt these drugs tap into the very real desires that many of us have to be, for example, less shy or bald or fat, or more virile. They make us feel these are medical problems with easy pharmaceutical answers rather than looking at the social context or origins. Of concern is the way drug companies use these legitimate concerns to sell drugs and make easy money, which distracts us from looking at deeper causes.

The consumer marketing of obesity drugs often lacks reference to lifestyle changes that are needed for a healthier lifestyle, and certainly lacks any reference to the responsibility of food manufacturers to reduce the salt, sugar and fat content of their products.

Drug companies are able to exert their influence in a number of ways. They are involved in committees that write the guidelines for how conditions are treated, such as blood pressure where they have influenced the decision to lower the level at which blood pressure needs treatment with medication. They are involved in the education of the medical profession – sponsoring many postgraduate educational events. They also use the media and patient groups to turn people into patients who need treating with their drugs (Moynihan et al 2002).

Drug companies are patenting medicinal plants, which means people who have traditionally used them for centuries will have to pay to grow and use these plants. In many cases, the drug companies have spent time in traditional communities and used their information developed over years of shared community health to identify plants and their effects. Indigenous communities often only discover that it is possible to own the right to grow and use a plant when they are informed a patent exists and



they can no longer do so. An example of this is the Neem tree that has been used for centuries in India as a medicine, toothpaste and fuel. US and Japanese companies have patented many of its constituents and the seeds are now only available at a very high price. Indian farmers are challenging the rights of these multinationals to the 'intellectual property rights' of the Neem tree.

Responding to the needs of shareholders and accountants, drug companies' main concern is profit. Birth control is a well documented example of how profit is put before human safety. Women have been made infertile, or have died in some cases, by the aggressive marketing and selling of unsafe products like the Dalkon Shield coil (Hartmann 1995). Drug trials are often carried out in the global South where no ethical approval is required and the subjects are often unaware that they are part of a trial, or that the drug they are receiving is not licensed. Much of this has come into our consciousness through dramatic portrayal, such as the recent film *The Constant Gardener* and a Channel Four documentary in the UK on drug testing in India (Iheanacho 2006).

Drug companies are not the only multinationals that profit at the expense of our health. Nestle do so with their sale of breast milk substitutes in areas where drinking water is unsafe. The World Health Organisation (WHO) estimates that 1.5 million infants die around the world every year because they are not breastfed. Where water is unsafe, a bottle-fed child is up to 25 times more likely to die as a result of diarrhoea than a breastfed child. Nestle are still cynically promoting milk substitutes for breast milk even though their aggressive baby food marketing practices have been exposed. Lifestyle health is a big earner and more and more high street shops, such as Boots, Tescos and Walmart, are offering free health checks and health advice. Sure enough, they have a solution and a product for sale too.

### **Health spending**

Increasing health care resources are often sold as the solution to our health problems but there is no definitive evidence that this is the answer. Funding research to increase understanding and develop new treatments of illnesses like cancer will undoubtedly improve the health of those suffering from these illnesses. But spending that targets the root causes which are often social may have more impact. Take, for example, the fact that those in lower social classes are more likely to develop heart disease or lung cancer. The major factors that have improved health in the developed world in the last century are improvements in sanitation and housing rather than increased spending on health. There are still large areas of the world without access to clean water or reasonable housing. Almost 50 per cent of all people in poor countries at a given time have a health problem caused by lack of water and sanitation, but this is not where

the cash is going (UNDP 2006). Health policy should be based on an evaluation of where increased resources would make the most difference. The most effective use of resources would be in the global South, preventing and treating infective diseases. Even improving support for isolated older people in the UK with chronic disease is a priority over checking healthy people's cholesterol. But it's the latter that makes most political capital and cash for the pharmaceutical companies (Heath 2005).

Interestingly those living in richer countries with more access to health care have higher rates of self-reported illness than those living in poorer countries. One reason for this is that due to the emphasis on preventative health, we are assessed for diseases we may develop in the future and given medications to reduce risks, such as raised cholesterol. In theory by reducing all our risk factors for ill health we should improve our health. The reality is that a combination of thinking we may get ill in the future from heart attacks or strokes and the side effects of the medications negatively impact on our mental and physical health (Heath 2005).

There have been several reports on widening health inequalities in the UK and across the globe which suggest that these can only be addressed by tackling income inequality and social determinants of health (Kawachi and Kennedy 1997). Solutions provided by medication are easier than challenging or changing our society – but this is the only action that will bring improvements in health for all.



## autonomous health

The combination of capitalism, medicalisation and coporatisation are detrimental to our health and we believe can only be tackled by taking an autonomous approach to our health based on self-management and self-empowerment. This requires an awareness that our health is in a constant state of flux affected by us and the world around us, some of which we can control and some which we can't. In difficult social situations it may be impossible to either have this awareness or to take any action to improve things – which is why real autonomy is only possible with radical social change. Without challenging capitalism and its widely pervasive influences we will only have limited control and choices. The structure of our society alienates and isolates us so we do not recognise that our problems, and therefore solutions, should be shared.

In taking a more autonomous, self-managed, approach to our health, our main point as outlined earlier is that everything about how we live and how our society functions impacts on our health. Taking more individual responsibility for our

personal health is a positive progression, whether it is doing more regular exercise, finding emotional support or, more broadly, aiming to be better connected with our bodily experiences. However, individual self-improvement is insufficient as an end point to good health since collective action is needed to tackle the widespread levels of unhealthiness that characterise our society. Our consumption based society sells us a solution to our health problems, in the guise of the ‘new age movement’, by encouraging individual self-improvement – as long as you can afford it – in the form of vitamins, organic food, gym membership or massage. These may be good for an individual’s health, but a substantial impact on health will only come with social change in which the lives of a much larger group of people are improved.

Autonomous health, to us, means a grassroots self-help approach relying greatly on preventative measures, as well as developing a political consciousness around the root causes of ill health. There needs to be a multifaceted approach to autonomous health involving different concepts and practical solutions including: self-help techniques; challenging the role of the ‘expert’ and demystifying medicine, confronting the causes of ill health on an individual and collective level; building support networks; acquiring skills and skill sharing; emphasising education and prevention; and taking action against factors which work against our health.



Figure 5.1 Zapatista health clinic

Source: Tash Gordon and Becs Griffiths

### Aspects of autonomous health

Within the constraints of our society there are self-organising, grassroots political struggles and groups that have been inspiring and made significant differences to peoples' lives. But, we cannot create spaces which totally escape the society we live in – we can't be completely autonomous. Collective organising can improve our health. It can be empowering, create new bonds and offer new answers, but it will not get rid of health inequalities or change some of the fundamentally damaging things about this world. Having control over our lives in a number of ways can give us increased control of health and hopefully improve it, and it can stop us feeling paralysed by feelings of powerlessness.



*Box 5.1 The health system of the Movement of Unemployed Workers, Argentina*

*In Argentina the MTD (Movement of Unemployed Workers) block the country's road infrastructure to paralyse the government and negotiate regular payments to the unemployed people. Some of the money goes directly to individuals, but most goes to funding community bakeries, workshops, nurseries, libraries, cafes and pharmacies to meet basic needs of the people involved in the movement. The MTD is in the process of setting up an autonomous health system. They have started by asking each neighbourhood group to pick a few health workers who then form the health commission. The first task undertaken by the health workers is to ask each of their neighbourhood groups to define what they perceive health to be, the barriers to their health, what is lacking in the health care they receive and what health care they would like to have available. The movement's ongoing popular education, apart from defining the health commission's work, is trying to raise consciousness about problems the people face, the underlying causes of these and how people could take control to improve their own situation. The plan is to enable sympathetic health professionals to give basic health training. There are already some workers trained to dispense medications, and others will soon be receiving first aid training, addiction training and a medical plant course.*

**Self-help**

Self-help is a term that became widely used during the second wave of the 1970s feminist movement. It encourages autonomy through information sharing, directly challenging the notion of the medical expert. Women formed small self-help groups to talk about their experiences of their bodies and of the medical establishment. By trusting their own subjective experiences they could explore their commonalities and their differences. They were able to develop political theories around gender and a political consciousness to tackle the cause of their oppression. Forming self-help groups can be a very important tool of autonomous health. It can create spaces where we support each other in processing the information we receive from doctors, the state and pharmaceutical companies, to explore for ourselves the problems and the solutions. It is important to realise that we are able to change some of the factors that cause health problems and this is much more effective and empowering than taking a tablet. There are many self-help groups now organised around every condition thinkable – a useful support network and way of sharing knowledge. The critique of this is that although useful, they are looking at each condition as a single issue without placing them in the broader context of how society impacts on our health.

**Developing a political consciousness**

We must realise that things will not change without taking on the politics that create the situations that are detrimental to our well-being. It is essential to understand how ill health is caused by the political system that we live in. For the Black Panther movement in the USA it was part of a wider movement to develop political awareness – as Blacks in the USA, they were oppressed and therefore education or health care provided by their oppressors would never meet their needs. Poor education, cheap alcohol and drugs enabled the white state to maintain the status quo.

**Skill sharing**

Sharing skills is an essential way of passing on knowledge, without relying on experts or paid officials, and building capacity and understanding that can be used for social change. Sharing skills and knowledge has been a long tradition in health. In many countries, for example, a number of activist or street medic collectives provide medical support during actions and demonstrations (see Chapter 6). Volunteers from US street medic collectives have also volunteered at the inspiring Common Ground Health Clinic. This was set up in Algiers, a poor area of New Orleans, following Hurricane Katrina. A wide range of medics and therapists staff the clinic including doctors, nurses, mental health counsellors, massage therapists, acupuncturists, osteopaths, physiotherapists, social workers and pharmacists. As well as running a clinic, they go

*Box 5.2 The Sambharna Clinic, India*

In 1984 methyl isocyanate, a deadly toxic gas, leaked into the town of Bhopal killing 20,000 people with an estimated 150,000 survivors and tens of thousands of children born with deformities. The company involved, Union Carbide, now owned by Dow Chemicals, paid very little compensation, failed to clear up properly, and allowed the groundwater to become contaminated. The state health care has been inadequate with indiscriminate prescriptions that have compounded the damage caused by the gas exposure. Survivors, doctors, social workers and activists set up Sambharna Clinic in 1995. Its task was to try and explore all the possible ways of improving the health of the survivors. It is run with no formal hierarchy of jobs, with every member of staff free to give opinions on every aspect of the clinic's work. The co-ordinator's role is on a two month rotational basis so that everyone has to take responsibility for themselves and everyone else. Decisions are made at weekly meetings by consensus.

A study carried out by the clinic in 1996 showed that a dozen transnational companies in control of the drug market in Bhopal were the chief beneficiaries of the disaster, even though there was enough evidence to show that their drugs provided only temporary relief. The herbal medicines and yoga used at the clinic is a direct challenge to this power as the herbs are prepared locally, are cheap and provide long-term benefits. All western medicine that is used is brought from the only non-profit collective in India. Patients are able to choose their own care plan, treated as holistically as possible, and their home lives as well as their health problems are looked at. The clinic believes that Bhopal is not an isolated event and that workers and communities are routinely poisoned all over the world. They believe the only solution is the eventual elimination of hazardous chemicals from the planet. They have found that there are limits to 'modern' medicine in tackling industrial diseases, and that the evolution of an appropriate system combining traditional and modern medicine is necessary.



on house calls and to satellite and mobile clinics and provide health education. They have seen over 7000 patients in their first three months. They provided free health care in a period of crisis and continue to run the clinic with the aim of creating a permanent community controlled, primary care health clinic.

### **Networks**

Personal and political networks are important. Having strong friendships and knowing we have personal support can play a big part in our health. In industrialised, capitalist societies, strong family and community networks have been lost. Many studies have shown that death rates or illnesses are two to four times higher among those who are socially isolated. One study found that after suffering a heart attack people with good social support are three times as likely to survive as those without (Wilkinson 2001). By building political networks without hierarchy we start to reduce the isolation of small groups and feel the political strength of many. It is also a good way of communicating, sharing skills and resources and thereby increasing our effectiveness. Activist Trauma is a recently created network in the UK. It is primarily for political activists who may have been injured during actions or other political activities and/or are struggling with mental health issues related to activism. They offer personal contacts as well as useful information around trauma and believe that supporting people who have been traumatised should be a central part of activism.

### **DIY health**

Basic health care does not need a health professional. Knowledge of basic first aid to deal with a minor injury or knowledge of local herbs to relieve symptoms of a cold or other common ailments means people can look after most of their health issues. For centuries this information was passed down through communities and families, but has slowly been replaced by a dependence on medical professionals. We need to reclaim and share this knowledge through courses, reading or setting up groups. Education about health plays a crucial role here. It can be done within self-help groups, by an individual doing their own research or in the context of workshops put on in places like social centres or feminist health clinics.

### **Direct action and self-organisation**

Today's society leaves most of us with little direct influence on many of the factors impacting on our health such as free trade agreements, pollution or war. Taking responsibility for our health includes finding new ways to challenge this situation and act collectively to influence the world around us. There are many examples of

people self-organising to improve their lives and health, including food co-operatives to increase access to affordable healthy food, taking direct action against pollution or climate change, community allotments to grow fruit and vegetables and strengthen community support, and many more which are discussed in Chapter 17.

## the way forward

In an ideal world there would be good quality housing, education that taught you to question and search for your own answers, land to grow food on, no repression and a supportive network of people. Some of this seems pretty unlikely but it doesn't mean that within the constraints of this society we cannot act to improve our health. Finding others is the first step and the next chapter offers many ideas of what groups can do to improve their health, be it starting a community allotment, a campaign against pollution or a health collective.



We would also like to see health care that improved health by working with people to help them meet their own needs, as defined by them. It is necessary to set up health centres that belong to the community rather than just health professionals. These centres need: resources that are made available to educate us on particular illnesses or ways of improving health; various types of health professionals working collectively and non-hierarchically; workshops on health issues; and a number of health collectives formed around different interests or needs. They could also have community cafes with cheap healthy food and eating and cookery classes, community allotments, bicycle co-operatives and workshops, and walking or cycling groups. People can take action together against wider issues impacting on their lives. This is our vision of autonomous health which can make society healthier, not sicker.

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