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ACTION AND INVOLVEMENT IN HEALTH GOVERNANCE

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Summary : Contemporary society analysis can't be the product of a "vision from up", but it implies that, if we have as aim an efficient reading, observation work have to be executed starting from "down", from "critical" elements of social relations, from "cast-off worlds" or marginalized by general sociological analyses. In this paper we want to emphasize a different way to think health equity. We have to try, in a collective way, to define health objectives through our understanding (and our opening to) concerning *active needs* expression, that is showed in relation with to the necessity of a specific moment, socio-cultural sector, cultural behaviour, that is from a particular setting and in a specific historical time.

Keywords: health needs, participated decision, therapeutic equivocal, health promotion.

Sociological observation has put in discussion not only the idea of society as coming out in the past, but also the ideas of every cultural reference, and the same match between social, cultural and personality dimension, because the shared relations world has lost own unity. So his members are dragged both in a modernity more and more characterized by desocialization and in contrast, in separate identity membership (and often separatist), misunderstood as able to link and keep culture and personality conjugation.

The attention to person and its harmonic location in different socio-cultural contexts suggests to sociologist above all the need of a strong sensibility towards values based relations, felt as really “collective” ones, on responsabilisation processes regards individuals in their formation of “their own sense of *we*”. So the sociologist is constricted to hypothesize interpretative categories that are connectable between holist and individualist dimensions.

In this world, where we are living, society is thought as a pure system of functional structures and objects and, in dependence from them, of individuals that felt themselves “together” and contemporarily “isolated”; person freedom is identifiable in “individualization” or with her annihilation in submission to a world without “subjectivity” [Touraine 1998].

Contemporary society analysis, therefore, can't be the product of a “vision from up”, but it implies that, if we have as aim an efficient reading, observation work have to be executed starting from “down”, from “critical” elements of social relations, from “cast-off worlds” or marginalized by general sociological analyses.

Many of these plans keep, in our opinion, the acceptance of fragmentation and disorientation, almost in the sense of autoghettoization, but on the other hand also the idea of a possible action aimed to sense and form recognition and their definition concerning person-subject idea.

OMS European strategy demands constructive information and education modalities, that can evolve in three big directions:

- increasing individual knowledge and competences on body and its functions health and disease, on bad health perception and about means to face a mental or physical malaise situation;
- increasing knowledge and competences concerning the use of health care systems and their mechanisms comprehension;
- increasing social, political and environmental factors consciousness hold which affect health.

From the operative point of view, it is important to underline some points from which a territorially centred programming can't disregard:

- keep count of context indications (territory and environment problem);
- define and make sense of damn images, on one hand, as a committed mistakes indication and, on the other hand, as a risks indirect reconstruction;
- built and directly represent risk images, their dynamics, diffusion (through a participated observation and highlighting, really well-known but often voluntary unheeded);
- analyze shared and sharable forms of health promotion and care activities (that means also to be able, because of a leaned mechanism to this aim, evaluate final and intermediate results).

Social inequalities research as regards health offers an interesting opportunities of rapprochement of holistic and individualist paradigms, as disease distribution in our society is stratified according to a monopolizing dimension, but on the other hand disease acts through individual typical mechanisms concerning his/her physicities: there are diseases “material” explanations (holism) and “non material” ones (subjective elaborations: individualism).

Socio-structural dimensions (social conditions, income, education grade, employment) have showed to be a consistent health determinant.

Anyway, it is interesting to observe that many epidemiologic data support the opinion that social or psycho-social environment affects health through paths that move social emotions, knowledge and motivations.

Other considerations derive from this opinion, for example the fact that favourable social settings to self esteem or trust strengthening in his/her own action represent also favourable settings to improve individuals health and, consequently, to raise community health levels.

What we know already is that health systems represent those inequalities belonging to a society. But the impulse of an equity ethical imperative represents an opportunity to overcome efficiency principles and lever on effectiveness dimensions in relation to real needs and social justice.

In this paper we want to emphasize a different way to think health equity.

Health protection, based on welfare principles, reflected more organization requirements than health needs, so treating of health warning, today we still have got a start-up historically concentrated mainly on care relation, rather than on preventive actions, on an high technicality and specialism of medicine, on health technical application, based on universality principles, rather than on logics of attention

as regards individual, particular, and group situations, on a high work splitting, with a lacked coordination between objectives, a consequent a high resources wastage, finally with a functionalization of citizens in high rigidity and staticity structures both organizational and of intervention.

The equivocal is determined by lingering on a *therapeutic* logic [Saccheri 2000] within a socio-economic system, that is more and more articulated, giving space to an evident exhibition of orientation diversity.

Attention is above all towards those citizens' *needs* we could define *passive*, because they are expressed, according to us, coherently to the services offer, so we have no possibility of expression concerning needs out of organization predisposition, already defined, of health care.

Health concept, instead, is eminently cultural and it seems to present peculiarities that, surely, can concern to individual physicity, but anyway they are defined on cultural values and patterns basis sharing by a certain society in a certain historical moment.

Relation modalities between citizens, structures and operators have been almost exclusively defined by services story rather than public health situations, so also those patterns that are submitted to individual and collective perception, that is diffused among operators and citizens, of *well-being and malaise conditions*, and access and communication modalities, that don't permit the expression of malaise, also when it is real, felt or objective.

Working on disease means to focus her/his own work on answers (often unsatisfactory answers), medical cares or custody, given to rigid or total institutions in which we develop a welfare and medical care activity; on the contrary, when we work focusing health concept we determine the fact that is impossible to act in a rigid coherence with prefixed schemes, out of the contexts and that are not modifiable, but on the contrary we have necessarily to reflect on goals of different activities, on objectives to reach and their coherence with the operative context, on verification of intervention efficacy. So we have to try, in a collective way, to define health objectives through our understanding (and our opening to) concerning *active needs* expression, that is showed in relation with to the necessity of a specific moment, socio-cultural sector, cultural behaviour, that is from a particular setting and in a specific historical time:

In disease terms

- passive needs vs
- de-responsabilization vs
- care vs
- custody vs
- total institutions vs
-
- medical care vs
- services policy vs
- decisions vs
- centralization

In health terms

- active needs
- responsabilization
- prevention
- socialization
- territorial structures and services
- social practises
- health policy
- decisions
- socialization

Health promotion projects are continually made just to maintain the existent and the educational idea to health has strong "dummy" undercurrents, subjects dimension matters little: they only meant in structural dimension logics, particular interests means that have nothing to do with health/disease real requirements of interested population, identifying themselves with administrators interests defence more than with citizens and operators one. In this sense, health promotion can be only affirmed where its meaning is not referred to a scientific/medical territory, but to qualitative aspects and person concerning contemporary life worlds complexity.

«Contemporary society places two obvious keys concerning the way in which research is made: first of all, the question of a participated research (...). In the second place, society also asks a major transparency in results dissemination, especially on topics which deeply touch human life and have got ethic implications, so we can produce a better informed public debate» [Miedes-Ugarte 2007].

May be, many reflections deficit is in the fact we have not much underlined that often needs persons and demand persons coincide.

Moreover the demand many times has been considered in its genericity and not as expression of social specific subjectivity or as typologization according specific peculiarities and types:

1. collective subjects demand, who operate for services or work organization change;
- 2 - collective institutional subjects demand, that is the demand which is made by an institution and aims usually institutional or organizational change;
- 3 - single subjects demand, codifiable according to procedures sometimes standardizable, sometimes not;
- 4 - single subjects demand that isn't accepted because organization limits, those concerning code capacity, crowding limits, tranquillity needs and finally for a deficit in competence.

What is the question, therefore, we can refer?

Is it possible (the answer tends obviously towards “no, it is not”) to distinguish between real demand and inducted, handled and mediated demand?

The passage from this short analyses to reconsideration of *participation* question is small.

As regards an integrated and sharing management of wellbeing promotional actions, it becomes clear that today we are in a deficient framework of tools concerning services and institutions culture: in this actual moment of transformation - not only the market - demand/offer or costs/benefits economic laws cannot be the only rational systems we can refer, as system survival depends on many social blocks:

- disturbances of economic and technical dimensions,
- changes of cultural patterns (and consequently of behaviours),
- the discontinuity and dis-homogeneity of social reactions,

act in outside and internal settings to services, making improbable the possibility of an organizational and regular and linear technical behaviour.

We should consider clear enough that projects realization to promote health have to aim well defined and delimited territories, which constitute natural interlocutors for who programs and operates, not only territories “ordered” configuration, but also for territories role as “negotiation” areas. These territories, together to different organizing realities, represent projectual development , verification and programmatic action settings.

If today, bringing back OMS’s formulations (old for now), we are in a condition to discover and be astonished, without considering obvious what we read, probably this is not a good result of made activities, and our suspicious is that all people said, is to complete yet, or even to start.