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Promoting Health, Social and Environmental Justice in the Context of Health Care Practice

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Abstract

The core business of health care is promoting and protecting human health. This is reflected in influential international declarations such as the Declaration of the Alma Ata for Primary Health Care and the Ottawa Charter for Health Promotion. Contemporary health care practice is guided by these mandates and recognises the importance of social justice and equity; inter-sectorial action on environmental, political and economic factors; community participation in decision making; and stable ecosystems as prerequisites for human health. More recently in response to greater knowledge of the health impacts of climate change and environmental degradation, health care agencies are becoming increasingly concerned with their role in the climate justice and the environmental sustainability agenda. Preliminary evidence from Victoria, Australia indicates that health care agencies are also engaging with the issue of environmental justice and how it intersects with social justice and health equity concerns. This chapter will highlight examples of emerging practice from five qualitative case studies of health care agencies in Victoria, Australia. The chapter derives its findings from individual and group interviews with health professionals and document analysis that explored the nature and scope of practice in rural, regional and urban health care settings. The study indicated that these health care agencies were broadening their practice remit to address the environmental impacts of their service provision as well as community-level environmental justice issues. This chapter features examples of practice at the nexus of environment-equity-health within public housing estates, public hospitals and women’s health programmes. Despite differences in approach, target population and context, the core finding was that health care strategies, competencies and frameworks were transferable to action on climate and environment-related issues in these settings. This assessment of health care practice is significant because it demonstrates some reassuring directions in the provision of health care and the development of an environmental justice movement in Australia.

Key Words: Health care, health promotion, social justice, environmental justice.

1. Introduction

The ultimate goal of health care and the environmental justice movement is to protect and promote the health of vulnerable communities. Both movements are concerned with addressing social injustice/inequities and protecting human health
from environmental harms/exposures. Despite vastly different origins, they both use strategies of community engagement, political advocacy, research, inter-sectorial collaboration and public policy development to achieve human health outcomes. Health care and environmental justice both operate on a world view that some social groups are disadvantaged by their relative position in society i.e. ethnic origin, ability to access resources i.e. income, and opportunities to participate in decisions that affect their health and wellbeing. Health care workers, like many environmental justice activists, are particularly concerned with ‘compound disadvantage’ and hence target their efforts towards marginalized or disadvantaged population groups.

Despite these obvious parallels, health care has not been a prominent partner in the environmental justice movement or the related literature. One possible reason is that health care, and indeed the broader public health movement, has been focused on the social determinants of health, and in doing so, has neglected its role in tackling the environmental determinants of health. This argument resonates with a popular analysis that the environmental and health agendas, formerly unified concepts within public health, have become disengaged from one another across time. The World Health Organisation’s (WHO) definition of environmental health excludes social and cultural dimensions and focuses on the toxicology of environmental hazards, and hence, may in part explain why across time the issues have been dealt with by separate disciplines. For example, the environmental health sector has evolved separately at the political, administrative and scientific level from the field of health care, which in turn, has meant health care workers have not been active in this space.

There is some anecdotal evidence to suggest that health care agencies and practitioners are in fact participating in this inter-sectorial space, but the practice has not been defined as environmental justice work. Again, this may be explained by narrow definitions and disciplinary silos acting as barriers to the development of an inclusive environmental justice and health discourse. Traditional definitions of environmental justice, in particular the civil rights based American definitions, have not been sufficiently inclusive of health-based practices/issues/population groups to ensure that this work is framed under the environmental justice banner. For instance, it is only more recently that topics relevant to the health sector such as food security, crime and violence as well as gender, age and sexuality have entered the environmental justice dialogue. This apparent lack of a broader, operational definition of environmental justice in a health care practice context has meant any health/environmental praxis has largely been hidden from view. In turn, this has stymied progress in health-based research which investigates the nature and scope of health care practice in relation to environmental justice issues.

So, where is the evidence that indicates health care is participating in environmental justice work? At an international level, the World Health Organization (the global peak body for policy, research and technical guidance in
health care) recently released a report titled *Environment and health risks: the influence and effects of social inequities.* This report sets out the evidence pertaining to social inequity and environmental burden and lists a series of recommendations for actions related to health care. The WHO, in collaboration with Health Care Without Harm, has also produced a series of case studies that demonstrate how health care facilities, i.e. public hospitals, are addressing their climate footprint and promoting the health and wellbeing of vulnerable populations living in heavily polluted areas. In an Australian context, Doctors for the Environment Australia (DEA) have released a series of position statements, one of which explicitly frames the health impacts of coal related air pollution within an environmental justice framework. In Victoria, Australia (and the geographic location in which this chapter is focused) there is some web-based evidence that demonstrates women’s health services are framing their practice as environmental justice work. However, most of this evidence exists as grey literature and solution generated practice is not captured. Furthermore, the evidence which is peer-reviewed is focused on identifying problems, as opposed to solutions being generated by health care agencies.

Given this apparent dearth of research, and in keeping with the idea that the concept of environmental justice can be advantageously applied across a variety of disciplines and environmental themes, this chapter presents examples of where health care agencies in Victoria, Australia are addressing issues at the nexus between environment, equity and health. This chapter also contributes to an emerging debate about the utility of environmental justice concepts in Australia - a country where environmental justice, both as a concept and a movement, have yet to acquire prominence.

2. Research Methodology

The findings presented in this paper are derived from a qualitative case study project which explored the ways in which health care practitioners were addressing climate change and environmental concerns in Victorian health care settings. The original data was obtained from interviews with health care practitioners in five health care settings and supplemented with documentary evidence. The data for this chapter was re-analysed using Wakefield and Baxter’s holistic research and action model for environmental justice – a framework that links a broad set of environment, equity and health issues.

Ten female health care practitioners (age range, 20-60 years) who worked in Victoria participated in the study. Five were designated health promotion practitioners and five were community health practitioners i.e. physiotherapist, occupational therapist. Individual and group interviews formed the basis of the five case studies, and data analysis was augmented by relevant organisational planning and evaluation documents provided by the research participants or public documentation accessible on service websites.
Maximum variation and critical case sampling strategies were used to identify cases that would yield wide variations on core themes.\textsuperscript{20} The cases selected represented the following: agencies that had explicitly identified climate change/environmental issues as a service or health priority; diversity in the nature of the health practices addressing climate change/environmental issues, i.e. by target group, strategy or issue; wide geographic distribution of cases, i.e. rural, regional and urban cases; and a range of healthcare settings, i.e. community health, women’s health, and primary care partnership (PCP).

Six semi-structured individual interviews were undertaken face-to-face at the participants’ agencies (or by telephone, \(n = 1\)) and were digitally audio-recorded. A series of open-ended questions centred on a schedule of topics were used to ensure in-depth responses about the informant’s experiences, perceptions and knowledge pertaining to the research topic. The group interviews of 2+ participants were based on a similar interview schedule and used to cross check individual accounts of practice.

Organisational documents supplied by the five organisations and information from the agency websites augmented the data pool. The purpose of collecting these texts was to fill any descriptive gaps about specific programmes. Document analysis allowed thematic analysis of core practices across cases (i.e. core strategies used) and also within each case (i.e. specific programme orientations). An ongoing dialogue between the researchers and participants was developed using email and telephone contact. Participant feedback was requested at several stages during data analysis and publication writing. These ‘member checks’ were conducted to verify the accuracy and credibility of the interpretations.\textsuperscript{21}

The analysis of interview and documentary evidence was guided by the principles of Stake’s case study data analysis and representation, namely, description, analysis and interpretations.\textsuperscript{22} The descriptive stage involved developing a profile of the work of each group, the settings, programmes and practices by manual grouping and then reading through texts, highlighting key words and themes and making margin notes. The integrative analysis stage was informed by procedures of cross case analysis and involved searching for positive and negative case themes and the development of a comparative table.\textsuperscript{23} This analysis step compared cases to identify similarities and differences between agency contexts and practices. The overall purpose was to find patterned regularities from the various data sources. The final step was to interpret core themes, i.e. to make assertions about the findings for health care practice in relation to the environmental justice literature.\textsuperscript{24}

3. Case Study Results

The findings are presented as five separate descriptive case studies that highlight synergies with environmental justice practices. Each case has been
constructed to emphasise a series of distinctive features, i.e. agency context, target
groups, settings for action, core issues and strategies.

Case study 1 highlighted the transport-related pollution initiatives of an inner
city community health service. The service had a long history of engagement with
clean air and environmental justice issues including political action to stop a
freeway development and conducting research into the impacts of petroleum bi-
products on asthma. More recently they had developed an environment-equity-
health agenda focusing on climate change. Active and sustainable transport was
one programme area of this organisation-wide climate change plan that was
consonant with conventional environmental justice approaches, i.e. engaging
public housing residents, who are from culturally and linguistically diverse
backgrounds (CALD), of a low socio-economic status (LSES) and at risk of
diseases associated with environmental pollution. Central to their transport-related
programmes was information provision consultation and advocacy for healthy
public policy. The health service considered action on the environmental
determinants of health, social justice and climate change its core business, and it
used health promotion mechanisms and resources to facilitate the process of
integration. One programme with environmental justice principles implicit to its
design aimed to simultaneously: promote community pride and participation;
improve the condition of residents housing and the built/natural environment;
increase opportunities for employment; improve health and wellbeing; prevent
crime and improve community safety; and increase access to government services.
By fostering social cohesion and developing community resilience this health
service was endeavouring to mitigate against the unequal distribution of
environmental burden and ensure equitable access to and involvement in
mechanisms used to address environmental issues.

Case study 2 was a regional women’s health service who had adopted an
environmental justice framework to ascertain the effects that climate change and
other environmental problems were having on, and would have on, women and
girls. They had developed a position statement on environmental justice and
garnered research to demonstrate that women are disproportionately affected by
environmental problems including climate change induced disasters. The service
had mounted an advocacy campaign to address environmental injustices based on
the perspective that women’s vulnerability to environmental problems stems from
the social construction of gender roles and unequal access to wealth and power. A
core strategy was to ensure that a gendered perspective is considered in local and
state-level environmental decision-making processes. The service focus was on
advocacy, partnership development and community education strategies in relation
to the issue of gender and disaster. They had formed partnerships with state-wide
emergency services, health and welfare services, women’s refuges and research
institutions to raise awareness of the issue of increased violence against women
following disasters. Using art, poetry, story-telling and photography as a medium
they were ensuring that women’s experiences are validated, and in turn, inform policy and programme development.

Case study 3 was a primary care partnership (PCP) located in a regional/rural setting. This PCP had undertaken various initiatives for local adaptation and rural adjustment to climate change that were consonant with approaches used in the environmental justice movement. One example of their work was the development of a policy signpost that would support emerging practice at the nexus between climate change, health and social justice in the health care sector. During the policy development process they engaged local stakeholders and brought regional/rural experiences of unequal and unfair distribution of climate-related burden, such as drought and water insecurity, to the fore. Another aspect of the PCP’s work was the development of inter-sectoral partnerships to ensure fairer distribution of programmes and services to rural communities. This was underpinned by community development initiatives in relation to local environmental concerns associated with energy, food, transport and water.

Case study 4 was a regional health service with one main site spanning acute care through to health promotion. An onsite community garden supported a range of health promotion strategies relevant to traditional environmental justice population groups, i.e. LSES and CALD as well as contemporary topics in environmental justice including community food security and the human-nature connection. Unique to the goals of this health service was a broadening of their focus to include ecological justice, i.e. non-human health and wellbeing. An example of this was their programme to promote habitat restoration for endangered animals and plants through the creation of a wildlife corridor. In this initiative they were reorientating their practice to be more ‘eco-centric’ and to address any harm that may have been done by purely human-centric approaches to health care delivery.

Case study 5 was a suburban community health service operating from within a large hospital network. A ‘green team’ in this health service were facilitating an organisational-wide agenda at the nexus between environment-equity-health by focusing on community access to healthy and affordable food and raising the profile of environmental issues among staff. Raising awareness of the environmental determinants of health and promoting a culture of environmental stewardships among staff was seen as the starting point for developing new practices. In their long-term strategic plan for an onsite community garden they were positioning themselves for mitigating against the impacts of climate change on the vulnerable population groups they serve.

4. Discussion of Case Studies

The findings show that the five health care agencies involved in the study have developed and adapted health care practices for action on environmental problems including climate change. Implicit to the practitioner’s descriptions of their
practice was that they were devising programmes which simultaneously promote environmental, equity and health outcomes. Each of the cases were addressing (albeit to varying degrees) 'compound disadvantage' and were based on the precautionary principle. The issues raised by the practitioners in the study were highly consonant with and related to those integral to the concept of environmental justice. That is, they were using concepts and tools which Charles Lee calls 'holistic, bottom up, community-based, multi-issue, cross-cutting, interdependent, integrative and unifying.' The significance of these findings is that it supports anecdotal evidence that health care agencies are engaging with, or beginning to engage with, environmental justice issues.

The reanalysis of the data also revealed some differences between the five agencies. For example, only two of the five agencies (case 1 and 2) explicitly used the term environmental justice to qualify the nature and scope of their practice. Whilst the other three agencies did not use the term environmental justice, their descriptions of practice were indicative of core environmental justice practices and concepts. These agencies were using core environmental justice strategies, i.e. public participation, targeting key groups i.e. LSES, focusing on contemporary environmental justice issues, i.e. food security, and focusing their efforts on geographically defined settings, i.e. a local government area. Further, all agencies were concerned with mitigating against the unfair and unequal distribution (distributive justice) of environmental burdens among the communities they serve, particularly in relation to climate change. However, only Case 2 (and to some extent Case 1) focused on its responsibility in promoting procedural justice, i.e. involvement of women or LSES in environmental decision-making. The implication of these differing levels of engagement with the term environmental justice and its core strategies is that opportunities exist for the sector to explore the issues and develop a framework to guide practice in this area. Further exploration is also required in relation to defining health care’s roles and responsibilities in environmental decision-making.

It could be argued that the ‘good fit’ of the data with environmental justice concepts was a direct consequence of the research design, i.e. purposeful recruitment of ‘foresighted practitioners.’ The research participants selected to inform the research were already operating within a social-ecological paradigm and within a disciplinary context, i.e. health promotion, which mandates action on the environmental determinants of health. These practitioners were apparently returning to the roots of good public health practice, i.e. the environment was not conceptualised separately from health. They also appeared not to be subscribing to the WHO’s definition of environmental health as they were considering all facets of environment i.e., chemical, physical, biological, cultural and social factors within their practice. The significance of this for the development of a definition of environmental justice in the context of health care is that existing frameworks,
such as the Ottawa Charter for Health Promotion, could be expanded to incorporate environmental justice concepts.33

These ‘foresighted practitioners’ were to varying degrees challenging dominant anthropocentric paradigms that conventionally disregard the symbiotic relationship between humans and the natural environment.34 Case study 4 displayed elements of an ecological justice approach to simultaneously promoting the health of animals, plants and humans.35 An eco-feminist perspective was displayed in case study 2 and a more traditional environmental justice perspective was evident in case study 1. These practitioners were pushing the boundaries of health care practice and engaging in new ways of thinking and acting for their sector. They were leveraging resources – human, fiscal and physical – to implement organisational and community-level ‘environmental’ initiatives to address the current and potential vulnerabilities of the marginalised communities they serve.

5. Conclusion

The significance of the research findings for the development of an Australian environmental justice movement is that there appears to be existing capacity within the health care sector to advance this agenda. The chapter revealed that opportunities abound for health care practitioners at all levels of the system to engage with environmental justice debates and to reorient their current practice. Indeed, a unique opportunity exists in Australia to develop the environmental justice movement from the platform of health care. Australian health practitioners, academics and policy-makers could be at the forefront of initiating a paradigm shift – which is called for in the literature on climate justice - toward a balanced view of human-nature relationships. If this was to occur, it would be what sets apart Australia from the United States and other countries where environmental justice is primarily an anthropocentric concept and/or used in its legal context.

Notes

13 Ibid.
14 World Health Organisation [WHO] & Healthcare Without Harm [HCWH], *Healthy Hospitals, Healthy Planet, Healthy People: Addressing Climate Change in*
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17 Environmental Defenders Office, Environmental Justice in Australia, 3.


24 Stake, The Art of Case Study Research.


30 Rebecca Patrick and James A. Smith, ‘Core Health Promotion Competencies in Australia: Are They Compatible with Climate Change Action?’, Health Promotion Journal of Australia, Special Issue 22 (2011): s28-s33.
http://www.who.int/topics/environmental_health/en/.  
33 World Health Organisation [WHO], *The Ottawa Charter for Health Promotion*, paper presented at the First International Conference on Health Promotion, (Ottawa, Canada: 1986), accessed December 4, 2010,  
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