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Climate change: How scientism has neutralised health policy effectiveness for rural communities



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A B S T R A C T

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Many countries have developed, or are in the process of developing, climate change adaptation policy statements, including for health. What knowledge do these policy statements value? How are rural community and Indigenous knowledges included? What are the implications of the answers to these questions for effective adaptation policy for health, particularly for rural communities? These potentially influential government policy statements have not yet been collectively analysed for the ways they reproduce particular discourses in the operation of their meaning-making for health adaptation. This international study investigates and maps health adaptation policy via a discourse analysis of an exhaustive set of twenty-one national adaptation policy documents from twelve Annex 1 countries in the United Nations Framework Convention on Climate Change. The study uses the techniques of critical discourse analysis to reveal that the national policy texts operate within an ordered universe of discourses that most values climate science and epidemiology and least values local community knowledge, needs and adaptive assets. This is true even for the discourse that emphasises particular forms of translational knowledge and methods for health services development critical to adaptation in these communities. In this respect, national adaptation policy, including for health, does not appear consistent with the prescriptions of global policy frameworks provided by the UN and WHO which emphasise local knowledges. The study's findings are explored with reference to critiques of scientism and Foucault's metaphor of the panopticon to suggest how national policy has worked as a mechanism for the appropriation, governance and regulation of rural communities, limiting its effectiveness.

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1. Introduction

Many countries, especially wealthier nations, have produced or are in the process of producing national adaptation policy statements, including for health. This study aims to answer three questions: What knowledge do these policy statements value? How are rural community and Indigenous knowledges included? What are the implications of the answers to these questions for effective adaptation policy for health, particularly for rural communities? In a context in which such policy documents have not yet been analysed, the study maps health adaptation policy using a discourse analysis of an exhaustive set of twenty-one national adaptation

policy documents from twelve Annex 1 countries in the United Nations Framework Convention on Climate Change. In so doing, it examines the consistency of these policy documents with best practice for health adaptation, including global policy frameworks for climate adaptation (COP, 1994, 2011; WHO, 2008), which emphasise the known resourcefulness of rural and Indigenous communities (Berkes and Davidson-Hu, 2010; Berkes and Jolly, 2001). Ultimately, the study seeks to extend understandings of the operation of a style of climate change 'scientism' as a technique of power shaping the effectiveness of this policy, especially for rural and Indigenous communities.

1.1. Community, climate and rural health

While international health policy frameworks from the Declaration of Alma-Ata on have emphasised the importance of community engagement and participation (World Health Organization, 1978, 2002), in practice national governments have been

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withdrawing from engagement for health policy toward expert consultation, which privileges biomedical knowledge and marginalises the local knowledge known to be critical to healthcare reform effectiveness (Meads et al., 2005; Morgan, 2001). Global climate change policy frameworks also emphasise the importance of local approaches to adapting to the threats of climate change. The Cancun Agreement (COP, 2011), which acts as the current key global policy framework for the UN Convention on Climate Change (COP, 1994), as well as the relevant WHO resolution WHA61.19 (WHO, 2008), all share an emphasis on the knowledge and experience of local communities, particularly disadvantaged rural and Indigenous communities. They also emphasise applied research methods and tools for adaptation decision-support and practical health service development. Accordingly, an important question remains for rural communities, far from urban hubs of consultation, about whether and how national policy translates this best practice global policy for climate change in ways that value local community, including Indigenous, knowledges.

The importance of effective health adaptation policy for rural communities cannot be overstated. The health effects of climate change are by now well-known and the subject of a growing body of literature: in PUBMED over 6000 journal papers variously addressing climate and health have been published, most since 1990. These effects are known to be shaped by socioeconomic factors. Climate change works to increase inequities in already socio-economically disadvantaged rural and Indigenous communities with already unequal health outcomes. Many rural communities are located in climate change 'hotspots' far from planning and early warning systems, as well as health infrastructure (Costello et al., 2009). The health effects of climate change are commonly conceptualised as 1) 'direct effects' of climate-driven events such as deaths and injuries from heatwaves, bushfires, flooding and cyclones, as well as 2) 'indirect effects' linked to, for example, shifts in the climate-influenced distribution and seasonality of flora and fauna linked to insect-borne diseases and allergies. Indirect effects have also been conceptualised as trauma from extreme events and suicide and depression from drought and displacement (Costello et al., 2009; Haines and Patz, 2004; McMichael et al., 2008; Patz et al., 2005).

1.2. Adaptation policy

Less is known about what kinds of adaptive responses, including in rural communities, would reduce the rising health burden of climate change. The fourth assessment report of the Intergovernmental Panel on Climate Change offers a commonly accepted definition of 'adaptation': an 'Adjustment in natural or human systems in response to actual or expected climatic stimuli or their effects, which moderates harm or exploits beneficial opportunities' (Adger et al., 2007). Four kinds of objectives of adaptation have been defined: building adaptive capacity pre-emptively, including building awareness; reducing risk and sensitivity; increasing coping capacity, after the fact, for extreme events; capitalising on the conditions brought about by climate change (Massey and Bergsma, 2008). The UK Climate Impacts Programme has identified four types of adaptation activities: 'share loss or share risk'; 'bear loss or bear risk'; 'prevent effects or avoid/reduce risk with a technical or structural change'; 'avoid or exploit changes in risk' (West and Gawith, 2005). Five domains of health service development where local adaptation activities should occur have been described: governance and culture; service delivery; human resources or workforce; material infrastructure; finance (Bell, 2011b).

A major deficit in adaptation supports and responses lies in adaptation policy. Policy-makers are already feeling this deficit: a survey of public health leaders in the USA suggested that the

majority of them felt unprepared and unable to make the needed health service adaptations (Balbus et al., 2008). A 2008 European study found that policy approaches to adaptation tended to focus on reducing risk and sensitivity and that health policy aims (disease management and extreme temperatures) formed 6–10% of all adaptation policy aims across the four European regions studied. Thirteen out of twenty-nine European countries had no health adaptation policy aims of any kind by 2008 (Massey and Bergsma, 2008). The extent to which such national policy deficits in health extend beyond Europe has not yet been mapped in a systematic international comparative study of health adaptation.

1.3. Health adaptation evidence

The absence of evidence to help develop adaptation responses to climate change is, of course, influenced by system values reflected in available funding. A 2009 study found the USA spent approximately \$3M per year on climate change and health research which was estimated to be 1.5% of what is required (Ebi et al., 2009). Australia's Health and Medical Research Council, administering the climate and health research funding program for one of the world's most climate-vulnerable wealthy countries, spent 0.23% of all biomedical and health research committed funding from 2000 to 2010 on grants with any relationship to climate change (NHMRC, 2012). Such figures suggest the hierarchy of evidence long taught in medical schools, which positions qualitative and community-based evidence as non evidence.

However, less well known is the growing cost to rural and Indigenous communities and health systems generally of this way of valuing research in a climate-changing world. A recent study of 19,164 social science and health science abstracts forming the corpus of climate change literature outside the natural sciences found that "rural" and "Aboriginal" concepts tend to be relatively infrequent (3% and 5% overall likelihood of occurrence, respectively) and are more associated with socio-economic concepts in the social sciences than the health sciences' where 'disease storylines' dominate (Bell, 2013). Serious deficits in community-based adaptive knowledge about, for example, extreme weather events management, have also been found for recent major flood events with rural mortalities, even in wealthy countries (Bell and Blashki, 2013; Teague et al., 2009). The IPCC's major study of the adaptation literature concluded that 'Data on disasters and disaster risk reduction are lacking at the local level, which can constrain improvements in local vulnerability reduction' (Bell and Blashki, 2013; IPCC, 2011).

Notwithstanding, a body of literature is emerging to define best practice, as described by us in another climate policy study, consistent with WHO (WHO, 2008), and UN (COP, 2011) global policy prescriptions. This is an ideal of national adaptation policy objectives and foundational evidence that value community knowledge; policy processes that use and document participative methods for including climate vulnerable groups; a focus on 'real world' health service domains under which adaptive responses are grouped to give the detail of implementation. In that study, we suggested that Health Canada has produced innovative health adaptation research for policy that offers elements of this best practice (though Canada does not have a national policy document for health adaptation to climate change) (Séguin, 2008) [authors TBA]. Of course, in the paradigm of critical discourse analysis we apply in this paper, our own definition of best practice is also itself a discursive artefact that serves particular interests in particular ways—ideally rural communities through our role as rurally-based knowledge brokers for policy.

In this paper, we explore what explicit national policy for health adaptation exists and what knowledge it values, particularly as it relates to rural communities. We explore how these policy statements work to create and normalise understandings of adaptation.

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