Australian Health Policy Institute
at the University of Sydney

in collaboration with

The Medical Foundation
University of Sydney

Where to from here?
The need to construct a comprehensive national health policy

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Australian Health Policy Institute
Commissioned Paper Series 2001/01

Published by

The Australian Health Policy Institute at the University of Sydney
Victor Coppleson Building (D02)
University of Sydney, NSW 2006
Australia

Reprint – September 2001
ISBN 1 86487 375 2

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Contents

Introduction 1

Some general considerations concerning health 4

Health determinants, principles and resource allocation 12

The concept of population health 18

The argument between population health and health promotion in Canada 20

Reasons for conflict between the population health approach
and health promotion 24

Policy change 27

The historical policy legacy in Australia 28

Towards a national health policy: One example 36

International policy change 38

Policy change in Australia 42

Conclusion 49

References 51

Commentaries - Jonathan Lomas 59

- Neal Blewett 68

- John McCallum 71

Introduction

The most important question with respect to health and health care confronting Australia now is, 'Where to from here?'. Given the huge resources that Australia contributes to health services, it is surely reasonable to expect that when choices are made about how to use those resources, the interests of those paying, those providing, those receiving, and those missing out should be considered. What are we trying to achieve? How do these aspirations mesh with our broader, national values? The multiple players, the size of the stakes, and the social importance of the issues mean also that health should be considered when more general public policies for the future of this nation are being developed.

We face five major challenges. The first of these challenges grows greater and more pressing and that is that there is far more that we can do - even limiting this to evidence-based care - than we can *afford* to do. Choices must therefore be made. Some people suggest that gene technology and related developments promise to reduce future health care costs but by far the biggest contributor to the steady and consistent 4 per cent per annum increase in real health care costs found in Western societies is the impact of new technology. Whereas in other industries new technology has reduced costs, it has done the opposite in health care. While gene technology has not yet worked, there is so much talent and investment in it that it probably will become applicable during the next decade, first with cancer, then DNA vaccines and much later on common chronic degenerations. But it will be prodigiously expensive, not only with high unit costs but also due to the support industry of screening, clinical geneticists, scientists and technologists and counsellors. Thus increased, not decreased, costs would be expected if gene therapy proves to be as successful as antibiotics, pharmaceuticals and fibre-optic endoscopes. Pinning our hopes of lessening health care costs to the star of medical technology is to pin them to the chief cost centre in currently rising health care costs.

Second, there is the problem of rising community expectations of health care. New medical technologies – from antibiotics to gene therapy – have much increased public confidence in what medicine can achieve. Some medical and media boosters have

pushed along the process of rising expectations with talk of greatly increased life expectancy and almost perfect health for future generations.

Third, the population is growing older and for a few decades – and possibly longer – we will be witnessing a relative increase in demand for medical care which is greater than would be the case if our population was not ageing. A number of European nations and Japan have populations with proportions of aged greater than Australia's. Their health care systems have adapted to the cost increases and they have avoided financial crises. Canada appears to be doing the same. The burden-of-disease picture in Australia is not as clear. Disability surveys reveal that rates of severe handicap in those 65 years and older increased in 1981-88, fell back to 1981 levels in 1993, but increased to a new high in 1998. Rates of less severe handicap also increased markedly in 1981-98. On the other hand, Australia is second only to Japan in WHO's recent rank ordering of countries by disability-free, life expectancy. (McCallum, 2001:4-5)

Fourth, there is an increasing political and probably population-based unwillingness to pay for a steady expansion of medical care through government spending alone, although the true state of public opinion is debatable concerning support for greater public spending on health care. Many surveys show that people are willing to pay more taxes for better health care and public support for Medicare has been very strong for some time. However, what these "motherhood" surveys about higher taxes and spending on health really mean is open to question. (Blewett, 2001:1) Also, given the strong revenue position the GST creates for the Commonwealth, this state of health care may in fact be more a question of the government's spending priorities than a lack of revenue. In any case, there is no justification to transfer all the problems, unresolved, that we are experiencing to the private sector. It does mean that new policies which give citizens greater choice need to be developed so that we draw less upon consolidated revenue for health care and more from other sources, such as health insurance along the lines of superannuation, rather than the variety we have at present. This needs to be combined with a re-examination of the basic services that government funding covers, because at the moment they are an odd assortment, although the primacy of emergency care and primary care will doubtless remain. But care for chronic illness needs to be looked at again.

Finally, all of us need to be better informed as citizens about health and health care so that our choices can be more intelligent and so that demands for health care become rather more restrained than they are at present. Medical care has become detached from some of the realities of life, of growing older, of having to die sometime, and the irreducibility of some pain and suffering. This is not a counsel of despair but of temperance when it comes to using medical services. Yet it is true that demand for alternative medicine is large and growing in Australia as in other parts of the Western world. Recent official estimates are that 57 per cent of Australians and 42 per cent of Americans use complementary and alternative medicine. The popularity of alternative practitioners arises in part from the failure of many orthodox practitioners to meet the needs of patients for caring, sensitive communication and coherent explanations. Orthodox medicine too often involves impersonal management of disease rather than care of people who have problems. (Baume, 1998a:42, Baume, 1998b:202-3, McCallum, 2001:2)

Social commentators speak of three principal functions of government - economic guidance; political representativeness; and socio-cultural responsiveness, the last dealing with preserving and yet encouraging debate about the principal values in our life as a society. Health has a stake in each of these three areas. If we fail to stimulate broad-based debate about the purpose of our health system, the omens are indeed dark. Growing inequity, increasing professional frustration, more litigiousness, cost escalation, and disgruntled patients, practitioners and public all wait in the wings. To prevent these misfortunes we need a clear national health policy.

This challenge requires a comprehensive response from our political leaders. It is a response that must take into account not simply the economic responsibilities of government but its role of leadership in matters cultural and social, its response to the full political spectrum of the community, and its sensitivity to issues other than economic wellbeing that make life worthwhile.

To show sensitivity to goals other than saving money is not ‘wet’ but rather is consistent with the historical mainstream of strong social development. These ideals are important not least when developing, announcing and implementing a health

policy and are strong motives in the lives of providers of hospital and medical care. Ignore these human aspects in health care and we won't even get the economics right! (Leeder, 1999:73-4)

This paper is written to encourage the quest for a national health policy for Australia. It begins with a consideration of the nature of health, its place in the life of the individual and of society. The social determinants of health and the social pressures that determine how we allocate resources for health are then considered. The intention to reach beyond medical care in the quest for better health began powerfully in Canada, and we provide an overview of the concept of 'population health' and the tension that arose between it and the more classical forms of health promotion.

The historical legacy that has led us to the present circumstances in health policy development in Australia is then explored, commencing in the 1880s and moving through to this year. Changes in policy setting internationally are then examined. We conclude with a section that explores how policy has been, and may in future be, changed in Australia, and the role that all citizens have in such an important task.

Some general considerations concerning health

Health is both an intensely personal experience and something of great social importance. Capacity to perform social and economic roles depends on a certain basic level of health and vitality. In modern societies, a significant proportion of collective resources is dedicated to the restoration and maintenance of health. Illness threatens our personal security, and, when serious enough, our lives. Consequently, every society, to protect itself and its individual citizens, allocates cultural and material resources to responding to illness.

In at least two ways health and illness are socially patterned. First, they often vary according to social groups – whether the groups are defined by class, gender, ethnicity or age. Further, the social patterning has a historical dimension, persisting over time in national populations; for example, continuing social class differences in health status in England during the twentieth century. We will look again at the issue of social patterning later, when discussing re-emerging concern with the determinants of health.

Second, health and illness are inextricably related to the social roles and relationships that constitute society at both micro and macro levels. At the macro level, the size and distribution of economic resources for curing illness and promoting health are significant political matters. At the micro level, illness impacts on the individual's capacity to sustain everyday relationships and to carry out the tasks of everyday life. Indeed, the first distinctive modern sociological analysis of health and illness, developed by Talcott Parsons (and his student, Renee Fox) in the 1950s, was that of functionalism. In this approach, health was a precondition of social action, and so integral to the functioning of the whole social system. Parsons conceptualised illness as the individual's incapacity to pursue everyday tasks and social roles. (Bury, 1997:1-4)

The Swedish sociologist Denny Vagero has pointed out that in surveys of popular attitudes health is repeatedly identified as a basic human good, and is usually seen as more important than wealth. Yet it is, as well as an identified good, a resource for the pursuit of life's goals. It follows that just as modern governments have concerned themselves with the distribution of income and wealth so they should be interested in the distribution of health. Vagero has suggested that governments have been much less concerned with the latter because they have not been convinced that policy can influence the distribution of health. Except perhaps for the concept of national health targets, adopted by some Western governments, health policy has for some years been about financial and managerial matters rather than the impact of services on the health of the people, although national health schemes were introduced in the belief that they would improve the access of citizens to health care facilities and therefore improve their health status. Moreover, health is more than a natural phenomenon. Most people are not condemned by their genetic heritage to a premature death. If we compare the same country across time or a number of countries at the same time, it is clear that social and cultural factors influence health and life expectancy. In principle, social, economic and health policies can improve life circumstances which will in turn improve health and life expectancy (Vagero, 1995:2-3).

Good health, narrowly conceived, is the avoidance of pain and suffering but in a broader perspective it is the means to pursue other goals. Human adaptability is such

that it allows us, of course, the pursuit of life goals with a range of levels of health. Good health is not the same thing as a good life, and, conversely, a good life is possible without complete healthiness. The adequate functioning of social institutions does not require a *perfectly* healthy citizenry, nor does the individual have to be *perfectly* healthy to take part in social life. Unless perfect health – in effect the eradication of disease and disability – is seriously entertained as the aim of the health system, good health is a question of how much illness and suffering is to be borne. Health is a good to be pursued, but not an absolute one. In this sense the 1948 WHO view of health as the 'complete well being' of the individual is an unrealistic goal for any health system and smacks of perfectionism. This perfectionism is Rene Dubos's 'mirage of health': 'Complete… freedom from disease is but a dream remembered from imagining of a Garden of Eden.' (Quoted in Callahan, 1990:253)

That health is both a social and an individual good is vividly portrayed in the great epidemics of history where the widespread illness and death of individuals breaks down central social institutions. But the link is also seen every day in modern society. According to the American health ethicist Daniel Callahan, the proper functioning of significant social institutions demands a sufficiency of healthy citizens. The robustness of a democratic polity where the rule of law operates depends heavily on the participation of healthy people, just as the national economy needs their physical and mental labour. The flourishing of educational institutions and the transmission of culture require healthy children, while the nurturant and caring institutions – families, philanthropic bodies, churches – also require a sufficiency of healthy people. The defence forces can only meet their obligations if a substantial body of healthy young people is available. Callahan argues that instead of progress towards an ultimately self-destructive goal of health perfection for all, we should strive for the lesser goal of sufficiency.

In developed countries, most people can now reasonably expect to die in old age (that is, 75 years or more). There is, arguably, already something approaching a satisfactory average level of health. However, this is the average, and the health of some social and ethnic groups is much below the average. On both equity and self-interest grounds, such groups should be assisted by collective means to raise their health status to that considered currently desirable and acceptable. Altruism aside, justice

demands they be assisted to improve their health. Moreover, there are socially shared ‘costs’, whether from the spread of infections and ‘social pathologies’, or the additional call upon public services including health care, that can arise from socially disadvantaged groups with poor health.

A sufficiency of health could be said to exist when the vast majority of citizens enjoy a level of health adequate to the performance of their social roles. Thus children have a sufficiency if the great majority are healthy enough to proceed through normal mental and physical development, and can be educated; adults, if the great majority can work, carry out domestic responsibilities and be involved in community activities; and the elderly, if a large majority achieve a life expectancy reaching the late 70s or early 80s still able to participate in interpersonal and community activities. For socially disadvantaged groups whose health is below the average the attempt to raise their health status would involve addressing social and environmental causes as much as, or even more than, improving their health care (Callahan, 1990: 103-30).

If the health system is to lay claim to being humane, it must strike a balance between the social and individual good; between the health of all citizens and the extra health needs of the few. Historically, the greatest health gains in the last 200 years or so have come in the first phase from improved living conditions, especially nutrition, and the public health practice of sanitation; and in the second phase, from immunisation and antibiotics. These were predominantly population-oriented approaches, not ones focussed on the needs of individuals. Indeed, the social good today for much of the world would be well advanced by a health system which was limited to good sanitation, a decent physical environment, decent food, immunisation, antibiotics, and trauma care. Public health, together with primary health care, would ensure that most people could adequately perform their social roles. It is when the system attempts seriously to provide for the many individual needs beyond those covered by this relatively simple combination of health facilities that a massive expansion of curative medicine occurs, especially when the individual wants of the elderly are increasingly engaged.

Callahan is concerned to see an economically sustainable health system established. He suggests that if society can no longer afford an open-ended, curative medicine

which aims to cure all disease and mightily to forestall death, then it can still afford, and ought morally to provide, caring for the sick or disabled individual in his/her vulnerability. Indeed, Callahan would make caring the primary task of health services for the individual patient. In a humane society caring represents an expression of solidarity and support in the face of the common experience of illness, and empathy in the face of suffering. It binds the sick and disabled to the community in the face of their alienation from everyday life and it overcomes fears of abandonment. Where the defeat of a particular disease will always be followed by the need to defeat another – the war never ends – the need for caring is a constant of human life. The capacity to provide care remains feasible even when funding of the endless quest for cure becomes impossible. Moreover, where the latter can degenerate into objectification of the patient or instrumentalism, caring promotes his/her dignity. With caring to the fore in health care, curative medicine could pursue more limited goals such as: assisting all citizens to have a full life to around the end of their 70s or early 80s; providing treatment for significant, chronic psychiatric disorders; and providing functional rehabilitation, where possible, to promote engagement in everyday life.

In order of priority, the objectives of the health system would then become:

(1) Caring, especially for people who cannot be cured or are too costly to cure.
(2) Pursuit of population health measures, especially disease prevention and health promotion.
(3) Primary and emergency health care.
(4) Advanced technological medicine such as chemotherapy.
(5) Very advanced technological procedures such as organ transplantation (Callahan, 1990:135-37; 1998: 270-74)

The Universal Declaration of Human Rights (1948) includes a right to a standard of living adequate for health. The European Parliament's declaration of fundamental rights adopted in 1989 recognises a right to life and a right to 'benefit from all measures enabling them (everyone) to enjoy the best possible state of health'. (Quoted in Vagero, 1995:15). But it would be quite unrealistic to claim an absolute right to health, even if we do not see rights in the traditional, natural law way but, less grandly, as historically recognised rules governing relations between government and citizens, and between citizen and citizen. An equal right to health of different social

groups is more realistic. Indeed, many Western governments have, in rhetoric at least, committed themselves to such an interpretation of equity in health. The equal right of social and ethnic groups entails having resources adequate to dealing with their unique health risks and problems.

In the social philosopher John Rawls's theory of justice, 'social primary goods' are distinguished from 'natural primary goods'. Health is identified as a *natural* good and so social institutions are assumed hardly to influence its distribution. But work on health inequalities over the last twenty years or so points to more than a marginal social influence on health. So, health should be shifted from Rawls's second category to his first. Then Rawls's theory, which applies to the justice of social institutions becomes applicable to health, as Daniels has suggested.

In a just society, according to Rawls, firstly each person has an equal right to the most extensive basic liberty compatible with a similar liberty for others, and secondly social and economic inequalities are such that both are reasonably expected to be to everyone's advantage and are attached to positions open to all.

Norman Daniels, in discussing Rawls's first principle of a just society in relation to health, concludes that his theory of justice must be seen in terms of fair equality of opportunity (not just formal equality of opportunity) if a person is to enjoy a fair chance of pursuing his/her basic liberties because state of health will constrain or facilitate capacity to pursue liberties. Fair equality of opportunity requires an equal right to health. The fact that health is a good in itself and also has an impact on future life chances provides moral justification for interventions to reduce health inequalities.

Paul Menzel moves on from the claim of an equal right to health (or health care) arguing that it may be a rational choice for a poor person to consume a lower level of medical care than a middle-class person, or to take greater health risks for a larger wage. Health inequalities arising from this rational and free choice are then not a moral concern, according to Menzel. (Menzel, 1992:38-40) But it may be argued, contrary to Menzel, that the narrower range of opportunities open to the rational poor person is itself a moral concern.

Not dissimilarly, according to Rawls's second principle of a just society, health inequalities might be morally justified if they are more beneficial for the disadvantaged than lesser inequalities or no equalities at all. Certainly, wealth inequalities have been justified on the ground that they are necessary to the economic growth which increases overall wealth and so benefits the poor as well as the rich. Such arguments in support of health inequalities are simply not advanced. What is commonly argued is that equal distribution of health requires equitable access to medical services. (Vagero, 1995:3-7) But while important to better health, equitable access may not be the most important path to that goal, 'The fact that we get an equal chance of being cured once ill – because of equitable access to care – does not compensate us for our unequal chances of becoming ill'. (Daniels quoted in Vagero, 1995:8)

Callahan argues that a fundamental conflict exists between the contemporary individual's wish for ever-improving health and the fact of our human finitude: '….we do not need unlimited medical progress to have a decent equitable common health … we cannot have an equitable common health if we pursue unlimited progress'. (Callahan, 1998:274) A well-organised and well-resourced public health system, an all-embracing primary care system, and healthy lifestyle, together with high levels of education, of decent employment, and of social security support will guarantee a healthy population, with the need for advanced technological health care minimally important. Callahan proposes that public health undertake the difficult task of modifying social and economic conditions which constrain health behaviour while at the same time insisting that personal responsibility be taken for health.

However, formidable obstacles stand in the way of achievement of a health system like Callahan's. The popular image of acute-care medicine (and biomedical research) is one of glamour, drama, and high rewards in terms of fame and financial recompense. It is strongly supported by a widespread cultural belief in unlimited, scientific progress, the legacy of the Enlightenment and modernist thinking, which post-modernist scepticism may have wounded but has not killed. It is also supported by another major Western cultural belief – individualism – especially in the United States, but, to a lesser extent, also in Australia. Individualism has in recent years been

revivified globally by the cultural and economic triumph of the market and a fetish for privatisation of economic infrastructure. There is hostility to government enterprise and programs, even in the historical heartland of the welfare state, Europe. In the United States, where the hostility is more deeply entrenched, it contributed to the defeat of efforts in the 1990s to introduce a universal health care insurance system, even when a majority of people favoured it. The retreat of government does not augur well for an emphasis on public health and health promotion, which are inextricably connected with the pursuit of the public interest, which only government is fitted to do. (Callahan, 1998:23, 173-87, Callahan, 1996: 885-86).

Callahan believes that, on the pathway to sustainability, first the economic costs of open-ended, technological medicine, and second, the demands of an aging population will become so great that not even the stratagems of the cost-controllers will be able to contain them. Of course, the incapacity can be disguised for a while by pushing the costs to the private sector with greater inequalities of outcome. The transition time might well be a matter of decades so those supporting the change need to have a long-term perspective. But this is not a counsel of complacency or despair, and a plan to push along change should be developed. It would show, first, how action to remove structural constraints can be combined with the encouragement of greater personal responsibility for health; and, second, how technological medicine can be used to fill the gaps in health provision left by even the most effective public health–personal responsibility strategy. It will be difficult to reconcile impersonal population-level measures with asking individuals to assume responsibility for their health. It will also be difficult to avoid victim-blaming when stressing the importance of voluntariness in behaviour change. (Callahan; 1998: 186-95) As Callahan points out, it will require 'a clever combination of efforts to change the economic and social circumstances conducive to poor health, and, at the same time, good educational efforts and a variety of moderate and measured incentives, a few coercive, designed to change individual behaviour.' (Callahan; 1998:201)

The discussion to this point has attempted to identify the place of health in the life of the individual and of society. From the premise that an open-ended, technologically ever-progressive medicine is economically unsustainable, and fundamentally misguided in its quest to banish disease from human affairs, it has sketched in rather

general terms the features and aims of a health system which no longer gives high priority to technologically-intensive health care. This alternative aims for a sufficiency of healthy citizens, not an attempt to meet all the needs of all individuals in every detail. It emphasises disease prevention, health promotion (including the encouragement of personal responsibility) and primary care, with greater attention to caring and less to curing at all costs. Health as a human right has also been discussed. An absolute right was considered utopian. But an equal right of different social groups seemed a realistic goal for a just society. Such a right entails possession of resources sufficient to deal with health problems.

Health determinants, principles, and resource allocation

It would seem logical in seeking to determine the nature of the health system, and the development of indices to guide the allocation of resources within it, to retreat one step to look at the determinants of health itself. Public health and social medicine have a long, if intermittent, tradition of concern with the social determinants of health. In the last 150 to 200 years, social explanations of health have waxed and waned within public health, itself subordinate to curative or clinical medicine. In recent decades, there has been a revival of concern, especially in the context of continuing inequalities of health status within developed countries, despite huge expenditure on health care services.

The radical German doctors Rudolf Virchow, Solomon Neumann and Rudolf Leubuscher, called for scientific investigation of the impact of social and economic factors on health in the 1840s. In 1847, Neumann observed 'the majority of diseases … are not due to natural physical, but to artificially-produced social, conditions'. (Quoted in Trostle, 1986:46) Friedrich Engels, drawing on the statistics compiled by English public health officers, argued in the 1840s that private ownership of the means of production and the resulting immiseration of workers were the fundamental cause of the excess mortality suffered by the working class in the new, industrial cities. The English sanitarians including Edwin Chadwick were well aware of the differential mortality between socio-economic groups but focused on the hypothetical miasma as the cause of most significant diseases. They called for a technical solution to banish filth from the physical environment, thus to reduce aggregate mortality – adequate sewers, drains and water supplies. The rise of bacteriology in the late 19th

century encouraged a focus on the pathogen as the cause of major infectious diseases dominating mortality at this time, and social explanations retreated further from thinking about the determinants of ill-health. Even when health experts like Newsholme and Newman in Britain in the 1900s investigated social class differences in infant mortality, they turned to individual education of working-class mothers in infant care, not redistribution of income, as the solution to excess illness and deaths from diarrhoea and associated conditions. In the economically depressed 1930s, there was a limited revival of interest in Britain in the social perspective on health in the work of Boyd Orr, M'Gonigle, and Titmuss. The implication of their work was that better provision of health care and social security services for poorer classes was needed to reduce class differences in mortality.

The attainment of apparent equality of access to health care after establishment of the National Health Service in the late 1940s put paid to official concerns about health inequalities until the 1970s. In 1977, the Labour Government announced that it would appoint Sir Douglas Black to chair a working group on health inequalities but his report, which appeared in 1980, after the coming to power of the Conservative government, was rejected. Its finding that lower social classes experienced higher death rates and poorer health and recommendations that substantial expenditure be made to raise the living standards of low income groups found no favour. Although calling for further research into inequalities, Black and his colleagues saw material deprivation as a key factor.

A second report on health inequalities, authored by Margaret Whitehead, appeared in 1987. It confirmed Black's finding that inequalities among working-age adults had increased from the 1950s and that in the 1980s the lowest classes experienced much greater death rates. But the Conservative government was as unmoved by this as by the earlier Black Report. (Lewis, 2000b: draft Chapter 9)

The Black and Whitehead reports showed that despite more equal access to health care provided by the NHS and, four decades of heavy expenditure on health care, the mortality gradient between social classes had not decreased even if the health care expenditure had contributed something to the reduction of average mortality. Although these inquiries suggested that the main determinants of health status lay

outside the health care system – in their case, poverty was identified as the key cause – health care was and still remains in Britain (and other developed countries like Australia) the primary focus of health policy and is thus politically endorsed, in effect, as the most significant determinant of health status. There is, of course, no question of the individual and social significance of health care in saving lives, abating pain and suffering, and maintaining function. Nevertheless it is unable to account for all the differences in health within and among populations.

Under the chairmanship of Sir Donald Acheson, a former Chief Medical Officer, another inquiry into inequalities in health in England was established in 1997. The report, published in November 1998, contributed to the development of the *Our Healthier Nation* White Paper. It identified several areas for policy development: socio-economic determinants of health (poverty, income, tax and benefits, education, employment, housing and environment, mobility, transport and pollution; and nutrition); life-cycle phases (mothers; children and families; young people and working age adults; older people); ethnicity; gender; and the NHS. The report made thirty-nine policy recommendations, some 'upstream' proposals relating to income, education and housing, and others, 'downstream' proposals, narrower in nature, like promoting physical exercise. Classified as crucial were: all policies likely to affect health should be evaluated concerning their likely impact on health inequalities; high priority should be given to the health of families with children and; further efforts should be made to improve the living standards of poor households. Government departments were encouraged to employ 'health impact assessment' so that the health effects of policies might be identified when making other policy decisions. (*Independent Inquiry into Inequalities in Health*, 2000, http://www.doh.gov.uk/ih/ih.htm, 27/4/2000)

The three inquiries and much other work carried out in the last two decades point to a more complex pattern of the determinants of health than that addressed by the traditional concern with health care. A health policy based on proper understanding of the relative significance of the different determinants would (other things like politics permitting) allocate resources accordingly. A better balance might then be achieved between support for health and non-health factors, and within the health system, among health care, health promotion and illness prevention.

Much evidence has accumulated on the role of supportive social environments in assisting people to deal with stress and preserve health. Indeed, while income and health in broad terms correlate strongly, high-quality social and physical micro-environments may be what are, in fact, most significant for health. With low or falling income, the maintenance of high-quality micro-environments may be impossible, or at least very difficult. Certainly, some countries achieve levels of population health higher than might be expected from their average income. Sri Lanka and the Indian State of Kerala are examples. Australian demographer, Jack Caldwell, has suggested that certain social factors, especially the level of maternal education (as a measure of care for children), may be principally responsible for that achievement. Focus on average income in any case may be misleading because, according to Richard Wilkinson, it is equality of income distribution which is critical to health. Wilkinson has offered three pieces of evidence: mortality is related more closely to relative income within countries than to differences in absolute income among them; national mortality rates tend to be lower in those countries having smaller income differences and lower levels of relative deprivation; and the long-term rise in life expectancy is not strongly related to long-term economic growth rates.

It is difficult to assemble all these materials on health determinants into a coherent model, let alone employ it to construct health policy. But, they are a long way from what Robert Evans has called the ‘repair shop’ model of health and health care policy. A major task remains to collect and synthesise the new knowledge which is being generated by biological and social scientists (Evans, 1994:3-24. Caldwell et al, 1990:534-40. Wilkinson, 1997:591). One piece of new knowledge relates mortality to lack of social support. Some think the strength of association is akin to that for mortality and smoking in the 1950s. But building a new model will not by itself bring policy change. The values, perceptions and interests of the major players more than new knowledge will shape policy.

The simplest version of the repair shop model sees health as the absence of disease or trauma, with the relations between health and health care at the centre. The sick or injured person (who has already made decisions about presenting with these problems which are influenced by his/her personal and social coping capacities) has his/her

needs for health care defined by the health care system. The response to these needs is determined by the access available in that society. Access is in turn determined by the available human and physical resources, and the financial and administrative arrangements which set the conditions in which services are provided. It is assumed that health care reduces the burden of disease and therefore increases health.

But forces act to cause health care systems to continue to expand, especially the claims of unmet needs as new diseases and conditions to be treated are defined, and the promises of new medical technologies. Although Western nations differ in the proportion of their wealth they spend on health care, tensions between expanding needs and resource constraint have become widespread across nations. Interest has thus grown in how effectively health care meets needs. Disciplines such as clinical epidemiology have arisen to help assess the effectiveness of particular procedures or treatments. If health care was easily achieving improved health status – if, for example, cures were available for common conditions like arthritis – the rising cost of health care would not be such an issue, in part because the cost could be met by the greater economic productivity (apart from the greater happiness) resulting from the cures. But this is not the case.

By the 1970s, the escalating cost of health care, and the failure of health care dramatically to reduce ill-health, promoted concern in relation to factors influencing health which lie beyond the health care system. The 1974 Canadian Lalonde statement with its four determinants of health – lifestyle, environment, human biology and health care organisation – expressed this concern and came to represent a turning point in thinking about health. It seemed to point to the emergence of a new, more comprehensive model. Health was explicitly recognised as the primary end of the endeavour. Three of the four determinants were outside the health care system.

In the event, however, the new model encouraged a focus on modification of individual risk factors in individual people to the detriment of interest in population-level factors and action. Thus, smoking was approached as harmful individual behaviour which heightened the risk of specific diseases. Risk factors themselves became ‘diseases’ requiring intervention by the health care system. But, except for tobacco companies, the role of powerful commercial interests or the impact of

economic and social policy was not addressed. The Lalonde perspective, in practice, failed to move us much beyond the established identification of health with the health care system.

The general relationship between social environment and health may be seen in the significant fall in tuberculosis mortality in 19th century England and Wales. The decline occurred before effective public health or therapeutic interventions were in place, and does not seem to have resulted from lower rates of exposure to the pathogen since the majority of people were still positive to tests for TB immune response even in 1940. McKeown has proposed that improved host resistance was due to better nutrition for the working classes, although this has been disputed. This historical example of declining tuberculosis mortality points up the fact that social factors can amplify or reduce the threat of disease. There is increasing contemporary evidence for the same thing. Thus, strong social support networks can protect unemployed persons from the health effects of economic deprivation.

In 1997, Australia spent about 8.3 per cent of national income on its health care. The United States spent more – about 13.7 per cent, and Japan less – 7.1 per cent. Growth of the health care system may negatively affect health by taking resources from other health-enhancing activities like aged pensions and other income support mechanisms or environment-improvement programs. Only within a larger health (as opposed to health care) policy perspective can the balance between these competing ends be assessed. Such a perspective would permit the connections between health, health care, wealth, and population wellbeing to be considered. The continuation of the old perspective, which equates health with health care, stands in the way of constructive public discussion of health policy, which, in turn, is part of the paradigm shift that emerging understanding of the complex behavioural and biological responses to social and physical environments demands (Evans and Stoddart, 1994:27-59. World Health Organization, 2000: 192-95. Australian Institute of Health and Welfare, 2000:234). As Evans and Stoddart point out, ‘appropriate conceptualisation of the determinants of health is a necessary but not a sufficient condition for serious reform of health policy.’ (Evans and Stoddart, 1994:60).

The concept of population health

This concept is as old as modern public health itself, which emerged and matured over the last 150 to 200 years. At its simplest, it involves viewing health at the collective level as opposed to viewing it at the level of the individual (and levels of bodily organisation below that down to the molecular). The latter is the perspective of clinical medicine. Public health has always been concerned with group indicators of health like mortality rates and general determinants of health like living and working conditions. As well as biological determinants, public health has also been concerned with economic and social determinants of health, and, sometimes, with the differential impact of these on social strata or classes. The Black and more recent British inquiries into health status inequalities are examples of the latter concern.

As noted, Black and other investigators have shown that a mortality gradient across social classes has existed in Britain for decades despite the more equitable access to health care created by the National Health Service and despite a considerable increase in average income. Further, the highest class has lower mortality than the next highest, even though both have incomes well above the average. So it does not appear to be just a matter of poverty.

In Canada in the last decade, another conception of population health has emerged from the work of the economist Robert Evans and others at the Canadian Institute of Advanced Research on the determinants of health. This work has had a marked impact on thinking about health systems and health services in Canada and elsewhere. In its concern to shift the health system away from a primary emphasis on health care, Canadian population health shares much with the international health promotion movement that developed so strongly after the appearance of the Ottawa Charter of 1986.

In 1991, Robert Evans and Greg Stoddart published in *Social Science and Medicine* a celebrated paper with the title, 'Producing Health, Consuming Health Care'. This contained the key elements of the population health approach. There followed in 1994 an equally celebrated book, *Why are Some People Healthy and Others Not*? and an issue of *Daedalus* on health and wealth. Evans and Stoddart accept Thomas McKeown's argument that medical care had almost nothing to do with improvement

in life expectancy in 19th century Britain. They play down the contemporary importance of health care as a determinant of health. Indeed, spending on health care is economically unproductive. Investment should be directed to the wealth-producing goods and services sector because economic growth brings health improvement. A major point made is that health policy should integrate biological, social, and economic considerations in a multisectoral strategy rather than focusing almost exclusively on effective, efficient and equitable health care. (Frank, 1995:233-37 Robertson, 1998:157)

The Canadian population health approach identifies health determinants at the individual and collective levels: income and social status; social support networks; education; employment and working conditions; social environments; physical environments; personal health practices and coping skills; healthy child development; biology and genetic endorsement; health resources; gender; and culture. It involves policies and interventions across the range of potential health action: health promotion; disease and injury prevention; risk assessment; policy coordination; medical treatment; rehabilitation; and palliative care. Health Canada, the Canadian Federal Health Department, has drawn up a long-term plan, *Blueprint to Promote a Population Health Approach in Canada,* to guide its work. It calls for six 'investment strategies': investment in theory, to develop theoretical frameworks; in policy, to embed the approach in policy development; in evidence, to develop the evidence base; in marketing, to advance the approach through education and marketing; in mobilization, to pursue the approach through insectoral action and partnership; and in institutional development, to establish the infrastructure to sustain the approach. (Population Health Approach-Health Canada http://www.hc-sc.gc.ca/hppb/phdd/approach/index.html)

Health Canada has explicitly recognised the relationship between health and social and environmental conditions: 'Health Canada recognises that health depends on more than a good health care system. Factors such as income, education, social support, networks, the environment, and employment and working conditions determine health and wellbeing. The Department focuses on this wide range of personal and collective circumstances when developing strategies to promote health'. It also states: 'This approach recognises that many factors, in addition to the health

care system, have a strong influence on health. The approach promotes prevention and positive action on determinants which affect the health of the population as a whole, or that of specific population groups'. (Quoted in Frommer et al, 1999:3-4)

In contrast, the focus of the Commonwealth Department of Health and Aged Care is on health services, not health. The Department sees itself as 'The leader in promoting, developing and funding world-class health and aged care services for all Australians'. Such services will employ a 'targeted approach to disease management and to addressing the health risks of particular individuals and communities'. (Quoted in Frommer et al, 1999: 4)

The argument between population health and health promotion in Canada

Proponents of health promotion have for some years been pushing for a broad approach to health, integrating social, economic and political factors with the biological, and moving beyond even equitable health services to deal with the determinants of health status outside the health system. Here the population health perspective corresponds with that of health promotion, except that population health claims to bring to bear more empirical evidence in support of the broad approach (Frank, 1995:237).

Population health by the early 1990s began to challenge health promotion in Canadian health policy as the countervailing discourse to biomedicine. The two approaches, as noted above, have much in common. Indeed, Health Canada in 1996 produced a synthesis in the 'population health promotion' model, which brought together Ottawa Charter strategies with a list of major health determinants and population groups. (Health Canada, 1998:14). Some health promotion people remain intellectually critical of 'population health' and concerned about the political uses that might be made of its rise to dominance in health policy. Some population health exponents, on the other hand, have expressed serious criticisms of health promotion. They argue that the concept of healthy public policy is 'imperialistic', with its claim all public policy (and indeed everyday life) has a 'health' component. 'In its extreme forms, this line of argument detaches the concept of "health" from any of its conventional and (potentially) objective measurable manifestations, and declares that health is whatever the people (which ones?) of a community (how defined?) declare it to be'. (Quoted in

Labonte, 1995:167). In reply, the health promoters ask what is a 'population'? It lacks the contextual referents of a 'neighbourhood' or a 'nation'. They point out, moreover, that population health has its own policy blind spots. Economic growth is the overriding aim of public policy for population health exponents, and investment in health care should be re-directed to wealth generation, which will bring the health advancement that health care fails to deliver.

The danger is that advocacy of lower health care spending dovetails neatly with the efforts of neo-liberal free-marketeers who, in seeking to balance government budgets and promote the private sector, dismantle the welfare state. Population health simply fails to see that 'the income inequalities it recognises as unhealthy may be caused by the very economic system it claims must be unencumbered by health care expenditures in order to generate more wealth and prosperity, and hence more "health".' (Labonte, 1995:167).

The radical health-promotion critics of population health extend their attack to its epistemological assumptions. First, it decontextualises data, using variables to produce statistics which are supposed to convey meaningful information about the real world. 'Underlying the notion of a variable', they say, 'is a vision of the universe as a collection … of relatively discrete and encapsulated items.' (Quoted in Robertson, 1998:159).

Second, the search for a single agreed discourse on health is undesirable because the discourse will differ according to where one is located in the larger social and political context. Health promotion seeks to empower communities to articulate their own discourses about health. While the causal mechanisms linking social determinants like poverty and racism have not been clearly established, a personal sense of control as a mediating factor is emerging as important.

Third, population health is proudly empiricist, eschewing theory. Yet, it does rely on the theory of economic growth in a capitalist system and a trickle-down distribution of its benefits. Simultaneously it fails to acknowledge the structural inequities of a social order based on a capitalist economy. Health promoters (some at least) point to the systemic inequities influencing the health of low-income social groups. Poverty is

a significant risk factor because low-income people not only experience more diseases but become more ill, and experience worse long-term morbidity and mortality.

Fourth, the population health approach offers a technical solution – economic growth – to what is a political problem – the redistribution of existing economic resources. Health promotion, by contrast, uses healthy public policy to promote sectors like public housing and employment. At the macro-economic level, it supports redistributive taxation policy. In its pursuit of social justice, health promotion embodies a clear normative element absent from population health which seeks to be value-free. It argues that the production of greater wealth will not by itself guarantee an increase in the health status of the poorest. This will depend on the net distributive effect of the greater wealth. 'Just' distribution is an unavoidably moral issue. 'The moral economy of a society is its set of beliefs about what constitutes just exchange: not only about how economic exchange is to be conducted in normal times but also …when poor individuals are entitled to social aid, when better-off people are obligated to provide aid …' (Quoted in Robertson, 1998:162).

The notion of moral economy takes analysis beyond economic and political factors to consideration of 'the moral structure of the economy and polity themselves.' (Quoted in Robertson, 1998: 162). The notion of moral economy has much in common with the concept of social capital, characterised by Putnam as 'the networks, norms and trust that facilitate coordination and cooperation for mutual benefit.' (Quoted in Leeder and Dominello, 1999:426). A society where social capital is abundant is not only more humane but also more efficient than one where it is in short supply. Trust facilitates social life. Moreover, collective provision of needs may be a significant component of the glue that keeps society together. State-supervised redistribution of resources, which has been the historical task of the welfare state, often serves as an expression of commitment to a just moral economy.

English social scientist and defender of the welfare state, Richard Titmuss, appreciated the integrative role of the welfare state and understood that welfare benefits were part-compensation for the social costs of a rapidly changing, capitalist economic order: 'They are part of the price we pay to some people for being part of the cost of other people's progress.' (Quoted in Robertson, 1998:163). Ironically, in

the context of international retreat from the welfare state, health promoters may be forced to oppose proposals to reduce state expenditure on health care because those whose health has been harmed by systemic inequity would be further disadvantaged. Also universal, state-funded health care symbolises collective support for a moral economy which seeks to redress the effects of this inequity (Robertson, 1998:157-64).

Black and others in the British tradition of interest in social inequalities in health have seen material deprivation as the key to explaining inequalities. But, as already noted, poverty as such would not account for inequalities between higher classes since they have incomes well above the average.

The work of Michael Marmot and colleagues points to psychosocial factors also being significant determinants of inequalities. His study of 10,000 British civil servants revealed that over ten years, for men 40 to 64 years of age, mortality in the clerical and manual (lowest) grades was about 3.5 times higher than in the senior administrative (highest) grades. A mortality gradient followed the hierarchy of civil service grades with mortality increasing down the grades. The lower grades experienced no greater apparent risk from the working environment than the higher ones. The mortality gradient existed for some conditions, some of which related to smoking but others did not. Those in the top rank who smoked were considerably less at risk of death from smoking-related conditions.

Marmot suggested that something related to hierarchy may be operating on levels of health. Evidence from non-human, primate studies indicates that rank in social hierarchies relates to capacity to deal with stress. Prolonged stress results in damage to biological systems, including heart disease. The immune system may be another biological pathway by which the social environment is connected with disease and mortality.

It is not clear, however, whether the higher mortality of Marmot's lower-rank civil servants was due to more stress, to the fact that they were less capable of dealing with stress, to their having less supportive work and domestic environments or to their lower incomes. The four may well interact.

Marmot's finding of a social gradient in the health status of British civil servants also offers strong support for the connection between 'relative' deprivation and health. His work, along with the work of Richard Wilkinson, points to equity as well as wealth being an important determinant of health. While Evans and Stoddart present the evidence for the importance of the social and economic determinants of health, they do not offer an integrated explanation of the social gradient in health status. Wilkinson does. His explanation involves the two dimensions of materiality and meaning – material resources we possess, and how we understand our being in the world - with both related to our position in the social hierarchy. Thus, the Evans model's concern with the biological and psychosocial pathways connecting low social status and poor health needs to be complemented by concern with the economic, social and political factors keeping the structural inequities in place. Further, expenditure on health care might well be lowered if the social and economic inequalities creating the ill health (which increases the demand and need for health care) were reduced (Poland et al, 1998:790-91. Hayes and Dunn, 1998:3).

Reasons for conflict between the population health approach and health promotion

Several reasons explain the conflict within the Canadian world of health research and practice. These include different conceptions of social science research, and different assumptions about the nature of society and what constitutes valid knowledge of it. The concept of population health developed by Evans and Stoddart is seen by health-promoter critics to be based on questionable positivist assumptions. These include notions of regularities in, even laws of, of human behaviour. Facts and ideas (or values) exist separately. Sensory knowledge of reality is more valid than any other. Humans by nature are rational, self-interested individuals. Independent, rational observers can agree about the facts as a prelude to the construction of a value-free social science.

At the other extreme in Canadian health thinking lies interpretative research, often employing participant observation and using detailed qualitative data to understand how people create their social worlds. Where the positivist assumes a shared meaning, the interpretivist assumes people hold various interpretations of social life. Facts are intrinsically linked with values and meaning, and no values, including those of

science, are privileged. Where proponents of population health look to generalisable relationships and abstract models, the interpretive approach seeks to describe and explain particular phenomena of everyday social life. So, as we have seen, Labonte criticises the population health approach for ignoring the phenomenon of differences in power and resources between social groups and the fact that these are inherent in the existing economic and social system.

Sitting somewhere between the extremes is critical social science, the purpose of which may be said to be the revelation of the hidden structures or forces governing the social world in order to help people bring about a better, more equitable society. It assumes that the social order is governed by hidden structures, which will become clear once the veils of social illusion are rent by the findings of the critical social scientist. He/she works consciously to bring about social change. This is unlike the positivist, who accepts the social status quo with its inequities and power differentials and who sets out to solve problems defined (in a self-interested way) by power elites (both government and private enterprise), not by people at grass roots level. Human behaviour is not fixed by immutable laws, but it is constrained by the particular cultural, economic and historical context in which people live. Facts do not exist in grand isolation but rather they are always interpreted within a setting of values, meaning and theory.

Thus, Robertson, as noted earlier, claims that the population health model of Evans and others, which is advertised as atheoretical, in fact includes a theory of social change. This is that improvement in health status is best produced by encouraging economic growth through market-based capitalism. Robertson also claims that the model reflects the dominant professional economic, political, and ideological interests of contemporary Canadian (read Western) liberal democratic capitalist society. Poland and others, as we have seen, argue that capitalism itself produces health inequalities and that the atheoretical population approach does not even consider looking into the relationships between health and capitalism, racism, and patriarchy.(Veenstra,1999: 518-21)

How then might we summarise as the key differences and similarities between population health and health promotion? One key difference is that population health

relies on increase in wealth to promote health status where health promotion (like those in the Black health inequalities tradition) looks to wealth redistribution. A second difference is that health promotion has not always provided a clear analysis of the determinants while population health has. A third is that health promotion usually stresses community development and participation, even when in reality much of this activity is made possible by government funding. Health promotion is not a grass-roots social movement like the women's, environmental or gay movements but it aims to encourage grass-roots activity.

Population health is not populist. Its primary purpose has been interpreting evidence about health determinants, not community development. Yet, population health and health promotion share the very important view that social structure and relations are critical in shaping health, thus shifting the focus from the biology of the individual and personal health practices. If social factors are so important, then from a policy perspective, health is certainly more than the health ministry's responsibility. Cross-collaboration between a range of ministries becomes vital. We will return to the issue of a model incorporating health determinants and health promotion strategies as the basis for a new policy approach later in the paper. (O'Neill et al, 2000:138, Dunn and Hayes, 1999: S9)

Despite such an apparent philosophical divide between population health and its radical health promotion critics, face-to-face dialogue between population health and health promotion has occurred in Canada. We have already noted that Health Canada produced in 1996 a 'population health promotion' model, a synthesis of Ottawa Charter strategies and major determinants of health. In the same year, a roundtable conference was held, involving population health exponents, health promoters, Health Canada bureaucrats, and members of the Federal, Provincial and Territorial Advisory Committee on Population Health (ACPH), the National Forum on Health, the Canadian Institute of Advanced Research and the Canadian Public Health Association (CPHA). Participant-driven, the conference acknowledged that there had been a history of tension between the two sides, partly because population health was becoming popular with governments just when community-based health promotion was enduring budget cuts. But it also acknowledged that there existed much common ground on which to build cooperation. Both were committed to advancing the health

of Canadians and reducing health inequalities, although where population health addresses the health gradient across all levels, health promotion focuses action on the disadvantaged. Both believed that medical care has a limited impact on health status compared with living and working conditions. Believing that they could not afford to remain at odds, they agreed to build a 'community of shared purpose' by pursuing the following program : creating more opportunities for dialogue; confirming common goals, values and visions; developing joint research and policy agendas; identifying flexible criteria for prioritising joint work on health determinants; building mechanisms for joint action by bodies like the ACPH and CPHA; and by showing respect for each other's position.(*Report of Roundtable on Population Health and Health Promotion*,1996: 2, 5-6, 10-18)

Policy change

Despite their differences, population health and health promotion proponents in Canada have found common ground. The Canadians are thus developing a new perspective on policy based on a health determinants approach which is informed by both population health and health promotion.

We have argued that on grounds of economic sustainability, effectiveness in dealing with the root causes of ill health, and equity concerning relative health status, policy drawing on Callahan's ideas and what is common to population health (both in the Evans and the Black tradition) and health promotion should be developed in Australia. This will need to be debated not only by health professionals but by a range of political and other interests and the community at large for policy change will not arise spontaneously from the rational discussion of scientific findings such as those presented earlier. It will be influenced to a greater or lesser extent by the political power of relevant interest groups. It will also be influenced by the conflicts of values among major players, including governments, health professionals and health industry interests, and citizens/consumers.(Lomas, 1997:29-33) Further, in the Australian federal system of government, Commonwealth–State relations influence health policy as they do much other public policy. Moreover, both sides of politics have seen health policy as essentially health care policy with partisan debate focussed on ways to fund health care. The repair shop model of health has prevailed. Prevention and

health promotion have at best been minor strands in the history of policy development.

Deleted: The historical legacy of policy – the 'inertia' in the system – will also impact upon the process of initiating change in policy. In Australia, this has been focused on equitable access to health care and modes of funding.

The historical policy legacy in Australia

Prior to the 1880s, when bacteriology began to give medicine a scientific understanding of the causes of many of the main diseases, the impact of medicine on health – its caring and palliative function aside – was slight. Unequal access to care was not a significant social or political issue because medical care made little difference to the outcome in most illnesses, and it remained only marginally effective probably until the 1930s. Moreover, the idea of collective provision of health care through state-mandated action was only beginning to develop in Australia. Care of the sick and infirm was viewed as the province of families (and within families, women), charities and religious bodies, not society as a whole. Health care was the responsibility of the individual supported by these social groupings. (Sax, 1990:51-2). Financing was organised as follows: the well-to-do paid their own way; the provident classes insured with Friendly Societies and Lodges; the poor received charitable services. Only public health was a state responsibility, something recognised to be of concern to society as a whole.

As medical care became effective across many conditions in the course of the 20th century, a social consensus slowly emerged that better access to care should be established. The Left and Right in politics differed as to how it should be organised. As early as 1910, a New South Wales Labor government was committed to providing, free of any charitable overtones, a number of public medical services, and was particularly concerned to make access to hospital care a right like that of access to primary education (Lewis, 1976:136). The Federal Labor Party publicly assumed a similar position nationally, in the context of the conservative United Australia Party government's proposal to bring in contributory national health insurance, when the Labor leader, John Curtin, told Parliament in 1938 that 'national health services should be treated … in the same way as education [and] should be free to all members of the community'. (Quoted in Thame, 1974: 315).

The experience of severe economic depression and the war against the Fascist powers led in the Anglo-Saxon democracies to a widespread desire for a more just and secure

social order and this aspiration was included in the Atlantic Charter of 1941. Also in 1941, the National Health and Medical Research Council (NHMRC) adopted for discussion with the (Australian) British Medical Association (BMA), a report composed by leading public health doctors, J H L Cumpston and R W Cilento, and others, which called for a national salaried service integrating curative and preventative work in a nationwide network of regional centres. The BMA opposed a salaried service, proposing instead in 1941 private practice funded by a compulsory contributory insurance scheme, and, in 1943, voluntary insurance. With the tide of war turning, the Curtin government began to introduce its social services program but it clashed with the organised medical profession over the *Pharmaceutical Benefits Act, 1944*, which was dismissed by the High Court as unconstitutional. Under the 1946 referendum, the Chifley government gained power over medical services (but not so as to involve 'civil conscription' of doctors). Its *National Health Services Act, 1948-49*, provided for the bulk of medical practice to continue on a fee-for-services basis, with half the fee to be paid by the Commonwealth out of general revenue; now only remote areas would have a salaried service. But the BMA remained wary of the influence of the Federal government as part-paymaster and it rejected the scheme. Labor lost power in late 1949 (Lewis, 1989:16. Lewis and Leeder, 1998:48-9).

The 1950s and 1960s were marked by the continuing dominance of health care in health policy and a retreat from Labor's concern with access as a universal citizen right funded out of the public purse. The conservative Menzies Liberal-Country Party government established by 1953 a national health service, aptly described as 'private practice publicly supported'. (Quoted in Sax, 1984:66) The key aspects were voluntary, private insurance, supplemented by public funds, and freedom of choice within existing medical and hospital services. It was intended to help those helping themselves and to preserve private enterprise; on this view, since government exists to encourage individual enterprise, government intervention should be limited to providing incentives to encourage citizens to insure and only the most vulnerable people, like state pensioners, should be fully funded by the state. The system continued with little amendment until the beginning of the 1970s, although there was much criticism of the costliness of private insurance administrations and the failure to cover a substantial proportion of low-income citizens. Labor, on the other hand, saw fair equality of opportunity and freedom as inextricably bound up so that governments

had to exercise power to deal with vested interests and social-structural impediments which reduce both (Sax, 1984:86-7; Lewis and Leeder, 1998:49). This fundamental difference of values and ideology continues to influence attitudes to health care organisation in 2000 after a decade and a half of Medicare, the tax-funded universal health insurance scheme.

The introduction of Medibank

With the return of Labor to federal power after 23 years of conservative rule, the Commonwealth government took a major initiative in prevention and primary care in the form of the Community Health Program. Yet, the Whitlam Labor government's support for public health expressed in this way was a minor theme in its health policy compared with its support for health care through the mechanism of Medibank, its tax-funded universal health insurance scheme, intended to provide equity of access for all citizens. It was believed that Medibank would more quickly establish equitable access to primary care than the Community Health Program could do. Although the Fraser Liberal-National Party governments, 1975-82, phased out direct support for community health centres, the legacy remained of a body of primary care workers committed to prevention and community-based health care at a time when the WHO had begun to shift the perspective on health policy in developing countries towards primary health care. The concept of primary care in the developed world was somewhat different and was seen as a counterbalance to the growth of specialist medicine in a technologically-driven hospital system. In Australia, the community health centres were a major attempt to advance primary care, which in part foundered because of the historical strength of fee-for-service, private, general practitioner care (Sax, 1990:2; Lewis and Leeder, 1998:47).

During 1949-68, Federal Labor in Opposition had talked rather vaguely of introducing a national health service similar to the one that had been set up in Britain. But the High Court's narrow interpretation of Federal health powers, and in particular the prohibition of 'civil conscription' of doctors, meant a court challenge by the medical profession would be very likely to succeed against a nationalised service. The plan of Melbourne economists, Richard Scotton and John Deeble, for a tax-funded universal health insurance scheme with free hospital care and, where doctors followed direct billing, free medical care, would not disturb fee-for-service, private practice, yet

would fulfil Labor's equity aims. The new Labor leader, Gough Whitlam, adopted this alternative, which was the more appealing because it resembled the new Canadian scheme accepted by both the community and the Canadian profession. Even so, after Labor came to power in 1972, its health insurance scheme, Medibank, was opposed by the Australian Medical Association (AMA), the private health funds, and the Opposition. After much political conflict, including a Federal election in 1974 in which health policy figured prominently, the Labor government introduced the medical insurance provisions in mid-1975, and soon after, following agreements with the individual States, free hospitalisation in public hospitals became available under Medibank.

The fall of the Whitlam government saw the Fraser government, in a step-by-step process, partly ideological and in part driven by anti-inflationary macro-economic policy, dismantle Medibank. From September 1981, there was in effect a return to voluntary insurance, with Federal rebates available only to those in registered funds, and an end to free hospital care. In 1982, the Labor party decided for economic, political and equity reasons, to adopt as policy, introduction of a Medibank-style scheme, Medicare. It was an anti-inflationary measure because as part of the 'social wage', it would discourage cash wage increase claims and it was incorporated into the Prices and Incomes Accord, negotiated between the Labor Party and the Australian Council of Trade Unions (ACTU). Political advantage might also result from electoral perceptions that Labor had a familiar scheme on offer in place of Fraser's confusing changes to health care funding. While Labor was moving towards a shared enthusiasm for free markets, in health care policy at least, it could be easily distinguished from the non-Labor parties. Finally, Medicare promoted traditional social justice objectives – more equitable funding, income redistribution and benefits for citizens not currently receiving them. In addition, it promised more control over medical fees, greater administrative efficiency and better information about medical service provision.

From Medibank to Medicare

The Hawke Labor government, elected in 1983, introduced Medicare in February 1984. Unlike Medibank, it was specifically funded by a levy of 1per cent on taxable income. Free care in public hospitals became universally available once more. The AMA at Federal level criticised the concept of compulsory insurance and direct

billing but did not oppose the new scheme. However, conflict between government and the medical profession broke out in New South Wales over Section 17 of the legislation which laid down that for certain diagnostic services in hospitals, only the schedule fee could be charged, and the agreement between the hospital and the doctor providing such a service was subject to approval by the Federal Health Minister. Doctors feared that in time all medical services in public hospitals would come under this provision. The Commonwealth ended this dispute by accepting that Section 17 be repealed. As in the 1940s and in 1972-75, the medical profession was able to exert considerable influence when its economic interests were threatened by a Labor government (Palmer and Short, 1994:60-74).

The Liberal-National parties made it clear in the 1987 Federal election campaign that if returned to power, they would dismantle major aspects of Medicare, reverting to private health funds for medical insurance. They were not returned, and a 1988 opinion poll found that 67 per cent of the population supported Medicare. For the 1990 election, they proposed tax credits for contributions, as incentive for the purchase of private insurance, and abolition of the national health insurance levy; further, each contributor was to pay the first $250 of his/her annual medical expenses. This policy had little appeal for low-income people without private insurance, for whom the levy was not burdensome. Under attack, the Coalition retreated from the scheme. When they introduced their Fightback policy package in late 1991 in anticipation of the next election, they accepted that Medicare should continue. But they wanted a greater role for private insurance: tax incentives for low-income people and penalties for high-income earners were to push people in this direction. In addition, substantial government subsidisation of the re-insurance pool would allow private insurers to lower contribution rates. Anticipating a fall in public hospital use, they looked forward to a reduction in Commonwealth funding under the Medicare hospital agreements. The Medicare medical benefit would be reduced to 75 per cent of the schedule fee. Gap insurance would be available to cover the gap between the benefit and the fee which was to be set in negotiations between the AMA and the private funds. But patients (except for pensioners) would still have to find 15 per cent as a co-payment with the insurance benefit. Critics pointed out how doctors could exploit the situation to increase fees, to the cost of both private funds and patients (Palmer and Short, 1994:75-6).

Despite much evidence that Medicare is widely valued in the Australian community, the Coalition parties, in government in the late 1990s, have promoted a two-tier health insurance system by providing public subsidies for private insurance. This is in marked contrast to Canada, which has many cultural, political, constitutional, and economic similarities with Australia. Although facing a worse budgetary situation, Canada has preserved its universal access health care system.

In the Fraser era, 1976-83, while the government contained costs by reducing its share of funding by more than 25 per cent, and passed costs on to users, the price of private health insurance rocketed. In the 1980s and 1990s, a number of factors acted to bring about cost stability: capping of hospital budgets; decreasing levels of uncapped private insurance; and the effect of Medicare bulk billing in slowing medical fee increases – in 1996-97, almost 72 per cent of extra-hospital, medical services were bulk-billed. Moreover, Australia from the early 1980s to the mid-1990s, was in a much better budgetary position than Canada. Where the combined government deficit averaged 2.8 per cent of GDP in Australia, in Canada it averaged 5.4 per cent. In Australia in 1994-95, total public sector debt was 38 per cent of GDP but in Canada, 100 per cent. Despite this, access has arguably been eroded here more than in Canada.

Although Australia has enjoyed a comparatively good budgetary position in the 1990s, Labor and Coalition governments have reverted to cost-cutting, which has diminished universal access. In 1990-91, a substantial increase in patient payments for pharmaceuticals was imposed and in 1996-97, charges to patients in the Pharmaceutical Benefits Scheme rose 20 per cent. In 1997-98, pensioners and low-income card holders lost the right to concessional rates for certain non-prescription drugs for 'less serious conditions'. In 1991, the benefit for general practitioner services was cut by almost 19 per cent but in the face of much protest and a leadership contest within Labor ranks, the measure was dropped. In 1997, under the new Coalition government, the Commonwealth Dental Health Program, serving very low-income people, was terminated. In 1996-97, people who qualified for part of the Family Allowance Supplement lost the right to Health Care Cards, and family planning funds were reduced by 10 per cent. In 1997-98, the waiting time for a Health Care Card was extended from 4 to 8 weeks.

As we have seen, historically, ideological factors and values in relation to health care have divided the two sides of politics. The non-Labor parties' traditional support for a strong private health care sector, reflecting belief in self-help and private enterprise, appeared to slip somewhat after their loss in the 1993 election was seen in large part to be due to their health care policy. Certainly, in the 1996 election, which they won, they said they would not dismantle Medicare. It is worth remembering, however, that in the 1996 campaign, both Liberal and Labor talked of state subsidisation of private insurance, and that not since the 1940s has an Australian version of the Canadian arrangement of universal access to care, free at the point of service, been seriously advanced in health care policy.

The economic recession of the early 1990s saw an acceleration in the rate at which people gave up private hospital insurance, and the private sector called for more government support for private insurance. Although Labor won the 1993 election, the Health Minister, Graham Richardson, began publicly to propose measures to increase the number of people with private insurance. The next Health Minister, Carmen Lawrence, won Cabinet approval in late 1994 for reforms to encourage the expansion of private insurance. From 1995, private insurance funds could set up preferred provider arrangements with doctors and private hospitals, aimed at lowering charges and so reducing user payments by private patients. In 1997, the new Coalition government introduced, on the one hand, subsidies of varying size for people taking out private insurance, and, on the other, penalties – extra Medicare levy charges – for those on higher incomes who failed to buy private insurance. In 1999, the Coalition government offered a subsidy of 30 per cent of the cost of private insurance. Subsequently, they introduced lifetime rating for private insurance, enthusiastically promoting membership of private funds. The Labor leader endorsed the Coalition government's 30 per cent subsidy.

Community support for Medicare

According to opinion polls, community support for Medicare was 44 per cent prior to its establishment, but had increased to 93 per cent by 1996-97. Yet, the main political parties support a two-tier insurance system. But, then, both user charges and a significant private hospital presence have been long-established features of the

Australian health care system. Further, where for three to four decades the major Canadian parties have agreed in their endorsement of universal health insurance, historically, in Australia, Labor has supported provision of state services and national health insurance but the non-Labor parties have wanted to minimise state intervention. Canada has enjoyed stability in health insurance organisation for three decades; Australia has shifted between state and private insurance a number of times over this period. Historical differences in organisation, in party politics and in people's experience of the health care system have produced different perceptions of what is the normal range of health care policy. (Gray, 1998:905-41; Gray, 1999-2000:5; Knight, 2000:21; Metherell, 2000:1-2) The contrast is, according to Gwen Gray, that 'debates in Canada since the 1960s have centred upon the value of a predominantly public system versus a two-tier system, whereas debates in Australia have been argued out in terms of whether a two-tier system, incorporating both public and private health insurance, is better than a predominantly private set of arrangements'. (Gray, 1998:941)

New directions

Although in some ways health policy in Australia, at least at the party political level, seems as obsessed as ever with health care, and in particular health care financing, there have been signs of a movement towards a more comprehensive view of health since the mid-1980s. The Commonwealth has taken the lead in several important public health initiatives beginning with the Better Health Commission's identifying national goals in cardiovascular disease, nutrition and injury, and emphasising improved prevention as the means by which to achieve these goals. Launching the Better Health Commission (BHC) in 1985, Neal Blewett, Health Minister in the Hawke Labor Government, noted that it 'represents the first concerted national effort to change the basic direction of health policy…for too long the emphasis in health care…has been on illness treatment rather than prevention.'. (Better Heath Commission, 1986:XII)

In the 1980s and 1990s the Commonwealth, States and Territories collaborated on a number of national strategies which targeted particular diseases, risk factors, population groups, and settings. Among the better-known was the strategy to contain HIV-AIDS which gave much weight to 'new public health' principles such as

prevention through health promotion and community involvement in decision-making. In the new public health, partnerships among a variety of players are fundamental.

Establishment of the National Public Health Partnership in 1997 provided new opportunities for such partnerships. An important contemporary challenge is the design of a system of public health governance to match the changing relationships between the Commonwealth, States and Territories. In 1995-96, a proposal for a National Public Health Partnership (NPHP) had been developed in discussions among the nation's chief health officers and public health professionals. The Howard Coalition government's Health Minister, Michael Wooldridge, supported the concept, and in October 1996 the Australian Health Ministers agreed to implement it as policy. It represents movement towards a more strategic approach to public health, overcoming the disadvantages arising from existing fragmented activities. The hope is that it will encourage the development of evidence-based policy and practice, and enable each jurisdiction to identify its proper role and set up appropriate infrastructure.

The NPHP has, through its potential to build co-operation not only between levels of government but between government and community, the capacity to promote a new public health emphasis on the social, economic and political context of health. But under the federal Coalition government, the focus of public health has tended to be on more traditional medical or behavioural concerns: national initiatives in breast and cervical screening and in immunisation; and substantial funding for development of preventive and population-based work in general practice (Lewis and Leeder, 1998:47, 53-55. Lewis, 2000a: draft chapter 8).

Towards a national health policy: One example

In April 1994, a discussion paper entitled *Towards a National Health Policy* was tabled at a meeting of all Health Ministers by the then NSW Health Minister, Ron Phillips. *Towards a National Health Policy* sought to chart a course toward improved health, increased satisfaction among those who use the system, reduced inequalities in health status among different groups in the community (especially the Indigenous community), and 'value for money'. It steered away from setting priorities and said

little about how expectations – of providers and recipients of care alike – could be modulated to fit within the limits of the resources available for health care. But for once, financing mechanisms came *after* a consideration of what they are for.

The paper was in three parts. The first part emphasised the importance of universal health insurance for essential care, the reduction of environmental hazards for better health, the development of measures of health outcome from health – service provision, support for health and medical research and the development of information systems that provide pictures of what is going on in health care. Each of these principles, which the paper argued support the overall goal of achieving the best possible health status for the population, would need first to be endorsed by all State and Territory Health Ministers and their constituencies, and then details of what they mean in practice worked out – especially in dollar terms. But in calling for agreement of purpose first, a chance for national cooperation at a high level was being offered.

The second section built on work done at both Commonwealth and State level in the last decade to specify goals: reduced deaths from road trauma, or reduced deaths from cervical cancer, for example, and targets – such as average blood pressure or weight down by 2 per cent within the next five years, let us say.

The third section proposed reform of the way in which health care is financed. Six principles were listed as essential for future progress: a clear assignment of responsibility among the three levels of government referred to above; a better working relationship between hospitals and general practitioners; the role of the private sector to be clarified and promoted; workforce numbers to be estimated; hospitals to be funded for the casework they perform; and doctors to be equipped to manage better both in hospitals and in the community.

The paper concluded with the recognition that widespread consultation is essential as the next step. (*Towards a National Health Policy*, 1994) The sense is of a long journey, but the need for a finished product is urgent. The policy received wide circulation and a final version of it was issued in mid-1995 by the Australian Health Ministers' Forum. By then Ron Phillips had been replaced as the Health Minister for New South Wales by Labor's Andrew Refshauge. In addition, another document had

emerged from yet another forum of Commonwealth and State and Territory discussion - a working paper prepared principally in Victoria which sought to achieve integration of services around the themes of acute, general and continuing care for patients. The first draft of the document set aside any consideration of preventive or health promotion activities until problems of integration of services had been clarified. This unimpressive, if not intellectually regressive, approach to health policy in Australia did not bode well. Subsequent modifications of the document fortunately offered hope that we have not entirely lost our grip on the realities of health in our rush to tend the machinery of sickness care, as though it were our exclusive responsibility.

In 1996 in the run-up to the Federal election, Michael Wooldridge, the most likely (and eventually appointed) candidate for the post of Commonwealth Health Minister under a Coalition government, prepared what is arguably the most comprehensive statement of policy intent seen in recent political history in Australia. It was notable not only for its length, but its coverage of many major issues and its commitment to various public health intentions, such as better immunisation, improvement in Indigenous health with special reference to the risk of HIV transmission, and evidence-based medicine where the scientific evidence of effectiveness is taken into account in determining how the health budget should be spent. Although perhaps not a national health policy, it addressed many of the issues that a reader might expect in such a document. This document has informed some, but by no means all, subsequent Coalition government intervention in health affairs.

International policy change

WHO Europe has already begun to incorporate the population health approach into policy. Zollner and Lessof produced a report in 1998 for the WHO Regional Office for Europe on putting the approach into action. Moreover, in bringing *Health for All* (HFA) policy up to date – *Health for All for the 21st century* – WHO has put more weight on population health concerns than was the case with HFA in 1984 and 1991, urging engagement with social and environmental determinants, including initiatives on poverty and social exclusion. Specific activities suggested to this end include analysis of the influence of socio-economic variables on health and collection of information on them; assessment of all public policy in terms of gender and equity

issues; mobilisation of protection for disadvantaged groups; development of fiscal and other policies so that access to education and social services is not income-dependent; and encouragement of both public and private sectors to take responsibility for reducing inequity.

It was not just a matter of putting more resources into health but with more intersectoral collaboration, resources going to non-health sectors like employment creation, housing, and transport systems could become resources promoting population health. In relation to resources, one of the biggest challenges for health professionals, bureaucrats and politicians to meet will be accepting their loss of power and authority as the community takes more collective responsibility for its health. Politicians in particular will be under pressure as short-term demands for access to health care have to be balanced against the long-term, less dramatic investment in population health. The implementation of a population health strategy will require attention to the following, according to Zollner and Lessof:

(1) securing of a powerful champion credible and able to act across sectors; in the first place, this would be the national government.
(2) construction of partnerships across the public sector, including State and local governments
(3) engaging of the private sector including encouragement of business leaders to champion population health as part of the private enterprise agenda and to develop a preventive, 'upstream' mentality.
(4) meaningful consultation with the people themselves to seek community preferences and legitimation of policy change, in a variety of settings – the workforce, the home and schools.
(5) monitoring of information concerning effectiveness of policy and practice.
(6) attempts to capture the popular imagination for the population health approach as the 'Greens' have done for conservation of the natural environment.
(7) promotion of accountability which is vital to monitoring progress and to empowerment of citizens; health and wellbeing impact statements could extend the model established by environmental assessment statements to the population health area (Zollner and Lessof, 1998:1-10)

As part of its campaign to encourage action on social and economic factors influencing population health, the WHO Regional Office for Europe asked the International Centre for Health and Society, University College, London to put together in an easily assimilable form for non-experts the evidence on the social determinants of health. The publication, _*Social Determinants of Health .The Solid Facts*_, of which Michael Marmot and Richard Wilkinson are the authors, shows how a range of social, material and psychosocial factors affects population health: work, unemployment, early life, addiction, food, transport, stress, social exclusion, social support and the social gradient. _*The Solid Facts*_ shows how material deprivation interacts with lack of social integration and psychological insecurity to influence adversely the health of people of lower socio-economic status (Dixon et al, 2000:87)

If citizens are to be involved beyond the ballot box and the democratic election process, means must be developed for community participation. Focus groups have been used for some time to bring members of the public together with researchers, policymakers and program managers to discuss health issues. But a focus group is a small and non-representative sample and recruitment is not uncommonly problematic.

Recently in the United Kingdom a more robust group concept, 'the citizens' jury', has been used to involve people in analysis of needs and decision-making, while combining the provision of information with deliberation and independence of professionals (the judge). They have been used, for example, to explore attitudes to, and policy implications of, genetic testing for disposition to common diseases.

Since members of citizens' juries are chosen using a form of random and stratified sampling, they may be said to be representative of the community providing participation rates are in excess of 80 per cent. Two moderators act as facilitators, with the jury being requested to analyse a significant, in this case a health policy or planning issue, over four to five days of meeting. The members absorb material provided, question expert witnesses and discuss the issue. The moderators draw up a report containing the jurors' conclusions, and this is received by each juror who may approve it, or amend and then approve it. The conclusions are not binding on the agency commissioning the project, and they may not even be unanimous. The agency is expected to publish the findings. (Macdonald, 1998:273-74)

Canadians have also experimented with community-level means for educating people about health determinants. Community health impact assessment has been used to do this and, at the same time, to empower citizens to participate in decisions affecting their health.

Nova Scotia in the 1990s embarked, as did other provinces, on health system reform, and the Health Department was moving to implement regionalisation and decentralisation. Three communities in Eastern Nova Scotia (which from a health perspective were burdened by geographical isolation and difficult socio-economic conditions) participated in the People Assessing Their Health (PATH) project, the aims of which were to assist citizens to identify factors determining their health and develop tools enabling them to assess the health impact of programs and policies in their own communities. The PATH process involved four stages: building the community process; facilitating community discussion; designing the tool; and supporting community use of the tool. All three communities produced tools – booklets – which, while reflecting the particular character of each community, yet recognised similar types of determinants of health.

The three communities identified employment opportunities as the most significant determinant. Other determinants identified (not ranked in order of importance) were healthy child development, lifelong learning, lifestyle practices, physical environment, fire and police protection, social support, stable incomes, and health services (acute care, home care, and primary health care). Mentioned as often as the health determinants were factors integral to creating healthy and sustainable communities: good communication (basic to greater community control); community involvement; local control and opportunities for leadership development; confidence in one's community; cooperation in service delivery; ethics, values and spirituality; and respect for one's culture and history.

The PATH process not only produced the health assessment tool, it enabled those participating to grow in understanding of determinants of the community's health, moving the perspective of many beyond the illness of the individual. The health determinants identified by citizens were more or less consistent with those embodied

in the professionals' population health approach. Further, the second list of factors identified as determining community sustainability involved socio-economic inequalities, and the participants' sense of control over their health. The process also created opportunities to understand the need for analysis of health issues of the whole region in addition to those of each community.

A very important lesson for policy change implementation emerges from the contextual history of the Eastern Nova Scotia community health impact assessment initiatives. Community-level involvement in policy change can only have practical effect if government-level (provincial or national) execution of policy occurs. This is where the funding and power to execute lie. In the Eastern Nova Scotia case, halfway into the PATH project, a wish to contain expenditure led the provincial government to desist from proceeding with community health board representation on regional health boards. The system-wide move towards community participation in health services decision-making ground to a halt. A withdrawal of government commitment to citizen involvement meant the relevance of community health impact assessment was greatly reduced (Gillis, 1999: 853-55).

Policy change in Australia

We noted earlier the growth of Commonwealth policy interest in population-level initiatives from the mid-1980s, even if the primary concern remained national health care funding. There are signs that health researcher and practitioner interest in the social determinants of health has increased in recent times.

A federally-funded Health Inequalities Research Collaboration was established at the National Centre for Epidemiology and Population Health at the Australian National University in 1998. The Collaboration sponsored a national conference on health determinants in mid-2000. In 1999, the Royal Australasian College of Physicians (RACP) published a booklet on the socio-economic determinants of health. It has also established a formal collaboration with the Australian Consumers Association and the Health Issues Centre to find 'sustainable solutions' to health sector problems. The latter two organisations supported the College's project on health determinants. The College stated that its commitment to the alleviation of ill health meant commitment to alleviation of inequality and poverty in Australia and New Zealand. With so much

evidence pointing to the connection between health and socio-economic factors, the issue was seen by the RACP as no longer one of idealistic reform but scientific and practical import. The College urged that:

- all levels of government develop partnerships with community, non-government, private and public bodies to examine the social and economic determinants of health
- before development of public and private economic, health and education policies, health impact assessment be carried out
- health promotion programs be funded to teach skills to cope with social change especially to disadvantaged groups like the unemployed, and
- State and Commonwealth governments continue their commitment to a universal health (care) system so that there is equitable access to health services (Royal Australasian College of Physicians, 1999:5-10, 34).

Experiments with citizens' juries are also beginning in Australia. The Medical Council of Western Australia in 1999 was engaged in looking at health resource issues and decided to widen participation in the debate beyond the health industry to include citizens. Scott Blackwell, chairperson of the Council, had attended the Watford Workshop on modernising the NHS held in the United Kingdom in November 1999 and proposed the citizen jury model used there be adapted and used at the Council's conference on health and economics in March 2000.

Two hundred citizens resident in Perth were randomly selected from the electoral roll. After 36 expressed interest, 20 were chosen. Financial reimbursement ($250 each) was offered but not before the first request for expressions of interest, so monetary reward was not a factor. Prior to the conference each citizen was asked to complete a survey about how health services resources should be allocated in Western Australia. Participants also met Medical Council staff, each other, and the two facilitators (one for each group of ten). Significant principles and proposals emerged from discussions. Group 1 agreed that *inter alia* a radical change in focus from treatment to prevention was needed in the health system and priority should be given to looking at long-term outcomes first and then matching activities to them. Resources should be shifted from

hospitals to prevention. It might then be expected the burden on hospitals would decrease as the population's overall health improved. The health industry needed to plan for a shift of resources from treatment to prevention. People needed to take responsibility for their own care but should still enjoy choice about the type of care they received.

Group 2 wanted a Ministerial Health Advisory Council of Citizens selected from the electoral roll and appointed for a 12-month period. This lay body would assist in the process of priority setting for the health system. It wanted priorities set at the national level but plans for implementation pursued at the local level. It opted for a mixed, private and public funding system for health care, and agreed that if taxation was to increase, guarantees were to be given that the extra revenue would be spent on the health system. Private sector funding (for example, from the dairy and meat industries) should be forthcoming for health promotion and preventive work. The organised medical profession must accept 'realistic standard' fees which are 'fair'. Health service expenditure decisions should be made jointly by doctors, economists, and citizen representatives (Medical Council, 2000: 3, 55-60).

In a pre-conference survey, of 123 questionnaires issued to health industry participants, 61 were returned (a response rate of 49.6 per cent), and all 20 citizen participants, comprising Groups 1 and 2, completed questionnaires. In the survey a substantial majority of both health industry people and citizens put spending on prevention/public health before treatment if extra health services funding were to become available. Both strongly supported the principle of equal access for equal need, but also supported positive discrimination in favour of disadvantaged groups including the poor and Indigenous people. The similarities between the health industry and the citizen respondents were thus marked. Differences included:

- citizens favoured more resources for Perth, while health industry people strongly favoured use of additional funds in areas outside Perth;
- both groups favoured 'positive discrimination' on equity, but the health industry group favoured it more, and;

- a substantial majority of health industry people saw more to health services than health, whereas a small majority of citizens saw health as the only product of health care.

This West Australian exercise of bringing health industry personnel together with citizens to address the question of the principles underlying health services is believed to be the first such formal joint initiative in Australia. The way forward in Western Australia might now be, first, to attempt a larger exercise, bringing together a more representative sample of senior people in the West Australian health service to find out if the current preferences are matched in the larger sample, and second, a survey of a larger randomly chosen sample of West Australian citizens and/or establishment of a number of citizen juries in various parts of the State, again to see how preferences look against those of the 20 randomly chosen Perth citizens (Medical Council, 2000:84-8). If politically feasible, there seems no reason why this two-pronged approach could not also be pursued at the national level so that principles to constitute the health system might be elicited from health services decision-makers on the one hand and citizens on the other.

The eminent Australian health policy creator, Sid Sax, published a book in 1984 entitled *A Strife of Interests* (Sax, 1984). The title came from a definition by Ambrose Bierce of politics as ‘a strife of interests masquerading as a contest of principles’(Quoted in Tripp, 1973). Sax's analysis was that the warring interests prevented easy progress and the policy-makers’ task was to manage the strife for creative purposes. Sydney surgeon, and now ethicist, Miles Little, recounted in June 2000 an experience he had with a group in Western Sydney convened in 1995 to determine the outcomes that might be used as measures of effectiveness and efficiency in the treatment of a number of chosen cancers. ‘After 12 months we reluctantly agreed that we had reached no useful conclusions’, he writes (Little, 2000). There was failure to find common ground among the experiences of patients, doctors, nurses, health service managers and health economists. There was, in short, a strife of interests of precisely the sort that Sax had noted. How, then, to move forward so that if citizens' juries or other forums are used to establish future community aspirations for Australian medicine, we achieve something?

The fate of the Eastern Nova Scotia PATH project is a salutary reminder that while direct consultation with citizens about fundamental policy issues like health determinants is important, its impact on policy is constrained by the larger political context. Direct or 'Athenian' democracy must be reconciled with existing formal sources of state authority and power as well as the reality of party-dominated government, and with the informal influence of significant material interests and prevailing ideologies. Historically, at least in relation to fundamental changes in health care policy in the English-speaking democracies, the timing of interactions between what was happening in the health care field and in the larger political world was critical. Major policy changes, introduced through what Touhy terms, 'windows of opportunity', resulted from complex interactions between ideas and collections of interests in the health care field and the 'agenda of the dominant political actors of the day'. (Touhy, 1999a:107)

Examples of windows of opportunity which have led to major policy change in health care are the coming of the NHS in Britain in the 1940s, and Medicare in Canada and Medicare and Medicaid in the United States, in the 1960s. Unless windows exist, efforts to effect change do not work, as the failure of the Clinton Administration in the 1990s to bring in national health insurance illustrates. The failure of the Federal Labor government in the 1940s in Australia to create a tax-funded national health system is another example.

The impetus for change must come from a government with capacity extensively to mobilise authority, and with the will to institute major reform. Historically, windows of opportunity have been few, and incremental change in policy has predominated. The opportunity for major change arises only rarely and may involve a shift in the power balance across state instruments, the medical profession, and private finance; or a change in hierarchical, market-oriented, or collegial instruments. The first three represent the key bases of power while the second three represent the instruments of social control, ordering and legitimising the relationships among the first three. Thus state actors operate through hierarchical (bureaucratic) instruments (significant in the United Kingdom), private financial actors through market mechanisms (significant in the United States), and professional actors through collegial bodies (significant in Canada and in Australia).

The windows of opportunity, which permitted major changes in the United Kingdom in the 1940s and in Canada and the United States in the 1960s, were noteworthy not only for the strong commitment of the governments of the time to change, but a larger political and economic context favourable to change. In the later 1940s, Britain was still affected by the widespread acceptance of a much expanded governmental authority, which the demands of war had legitimised. In the 1960s, Canada was experiencing economic prosperity and government expansion. A universal system of medical and hospital cover supported by the state appeared quite feasible. The same political and economic outlook prevailed in the United States, but public cover was restricted to the aged and the poor because universal health insurance seemed too large a step given the long history of failure by supporters since the early 20th century to carry the day (Touhy, 1999a; 243-44, 262-64. Touhy, 1999b: 116-20)

Since the population health approach (including amelioration of health inequalities) demands a major change in policy championed by the national government, it is difficult to see a window of opportunity opening in the near future in Australia. Much more likely is further conflict between the major parties over the long-established issue of health care funding, especially the balance between public and private sources of finance for insurance cover and the balance between Commonwealth and State responsibility for funding. As we have seen, the Howard Coalition Government and the Labor Opposition are focused on health care insurance funding with conflict about the balance between public and private funding contributions to health care cost. The population health approach may be of increasing significance to health researchers and practitioners but the window of opportunity to translate it into a major policy change has not even begun to open in Australia. But we must be ready for it when it does open.

What might a health policy program based on Callahan’s ideas and on a model incorporating population health’s health determinants and health promotion’s strategies for influencing those determinants begin to look like? First, it would follow Callahan’s ordering of priorities: caring; pursuit of public health measures; primary and emergency health care; advanced technological medicine (like chemotherapy); and very advanced technological medicine (like organ transplantation). Second, in

pursuit of a population health approach, it would employ what the Canadians have termed the "population health promotion" model (refer Attachment 1). This model involves action across the range of health determinants using the health promotion strategies identified by the Ottawa Charter and interventions at various levels of social organisation from the individual to society as a whole.

The five health promotion strategies – reorient health services, develop personal skills, create supportive environments, build healthy public policy, and strengthen community action – are set against the nine health determinants – income and social status, social support networks, education, working conditions, physical environments, biology and genetics, personal health practices and coping skills, healthy child development, and health services. Evidence-based decision-making supports the cube making up the upper part of the model. The three sources of evidence are research, experiential knowledge from practice, and evaluation studies of policies, programs and projects. The whole model rests on a base of assumptions which embody certain values. These assumptions are:

(a) decision-makers agree that all health determinants need to be acted upon.
(b) health organizations not only act on determinants for which they have direct responsibility but attempt also to influence policies of other government sectors which impinge on health.
(c) while interventions may take place at different levels of social organization, overall coordination of activity is needed.
(d) reduction of health status inequalities requires change at the macro-level of social values and structure.
(e) the health of individuals is a resultant of both personal health practices and the impact of social and physical environments; settings impact physically and psychologically on the health of the individual.
(f) environments where a high degree of social justice exists and where relationships are based on mutual respect and caring rather than power and status are required for the optimisation of health.
(g) disease prevention, health protection and health care complement health promotion, and community participation in policy development and implementation is necessary if people are to have influence over the decisions

affecting their health. (Developing a Population Health Model http://www.hc-sc.ac.ca.hppb/phdd/php/php.3htn)

The above assumptions reflect the high value placed by us on a social-factors approach to, or social conception of, health, on addressing health determinants and reducing health status inequalities, and on caring, equity, and community participation in health matters. Pursuing a comprehensive policy based on a social conception of health, health sector organizations will need to continue their current role of providing direct service in the form of funding, knowledge and technology. But they will need more and more to serve indirectly by influencing other sectors the policies of which affect the health of the population.

Since on our analysis key determinants of health lie outside the health care system and since inequity in the distribution of social and economic resources makes for health inequalities, there must be strong emphasis on more equitable economic and social policies. However, if the health care system is to deal equitably with the disproportionate burden of ill-health carried by the disadvantaged, and at the same time help promote social solidarity and cohesion, the universal, publicly-funded health care scheme, Medicare, must be sustained in some form.

Policies devoted to the reduction of poverty and more equitable income distribution would be at the head of the list. Greater investment in public education at all levels would also be necessary, as would housing policies aimed at increasing the availability of state-owned accommodation and reducing urban homelessness. Such policy implications clearly require the health sector to be committed to intersectoral collaboration in policy development and monitoring of policy implementation.

Conclusion

In summary, the development of a comprehensive Australian health policy which seriously takes into account current knowledge about the range of health determinants and the causes of health status inequalities still eludes us. But central to development will be a social conception of health, which requires the health sector to take seriously intersectoral collaboration. It also requires governments to think carefully about the linkages between health policy and social and economic policy. It is essential to

recognise that the international evidence suggests that no form of health insurance, public or private, Commonwealth or State, will control costs so long as there is no limit to medical practitioners alone deciding how much to spend on an individual patient. The unfettered practice of individual medicine, without regard to public cost, and characterised by wild disparities in the rates of diagnostic and therapeutic procedures from one area and socio-economic class to another, makes no rational economic or ethical sense.

While not denying the difficulty of the task, the need for a comprehensive health policy that expresses the central aspirations of Australians with regard to health and health care *and* defines the limits and priorities is essential if the best use is to be made of limited resources in the face of unlimited demand. The central players in this debate should be our politicians who must learn to present real options in their election platforms beyond the ritual mouthings of benefits and costs of different ways of paying for health care, important though that matter is. There are many others to invite to the policy table as well and the process of development of such a policy we know is not easy. But if we succeed with an area as expensive and value-laden as health, much else will follow with great benefit to the community.

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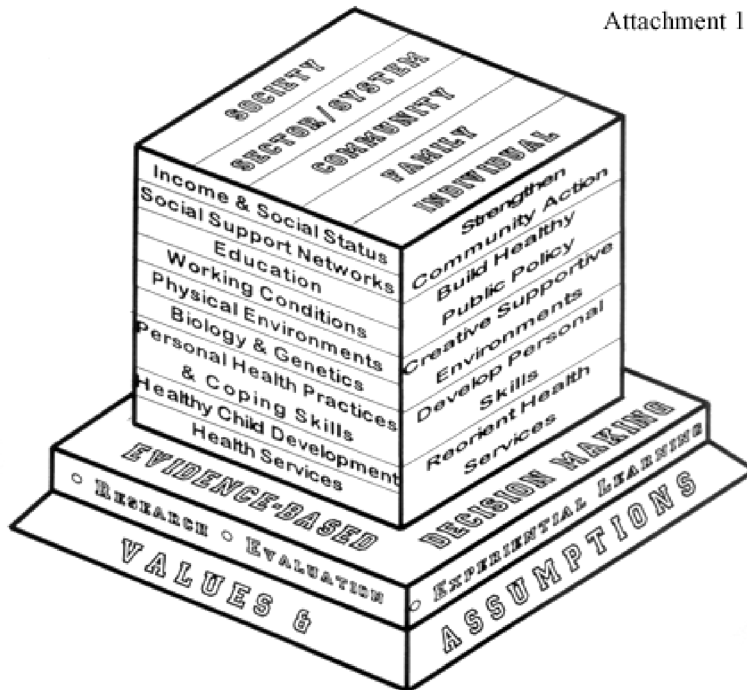
Attachment 1



Source: Hayes and Dunn, 1998:54.

Macchiavelli meets Ivan Illich

A Commentary on Milton Lewis and Stephen Leeder's call for a Comprehensive National Health Policy

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Near the start of their paper Lewis and Leeder bemoan the fact that 'health policy has been about financial and managerial matters rather than the impact of services on the health of the people'. The laudable premise of the paper is that this must change; that form should follow function and that the function of a society's health system is to improve its citizens' health. Their call for a national health policy is the cry of the rationalist: given this function, assemble the options; decide, with democratic involvement of citizens, which are the most effective options to achieve health improvement; finally, design the priorities and the 'form' of the system accordingly.

This premise is remarkably straightforward and simple. The arguments they then put forward to justify the need for and describe the elements of a new health policy are not so simple. The five main strands of the paper are, therefore, worth recapping here in brief.

We're rearranging the deckchairs on the health care system Titanic
The pressures of new technology, an aging population, and increasing chronic illness are on an inevitable collision course with the current health *care* system because of its open-ended funding and the 'population-based unwillingness to pay for a steady expansion of medical care through government spending alone'.

Health care isn't that important anyway
The individual services of health care are far less important to overall health than population-oriented approaches such as 'good sanitation, a decent physical environment, decent food, immunisation, antibiotics and trauma care'. A humane society is obligated to attend to the inequalities that are resulting from too much attention (and funding) to health care and not enough attention to the broader determinants of health. Resources can be freed up for this larger task by defining a 'basic package' of publicly funded health care with highest priority to caring and the pursuit of disease prevention and health promotion.

Internecine warfare between health promotion and population health is a barrier to progress
Health promotion and population health have been the main rallying points for those interested in the broader approach that expands service beyond traditional health care. Unfortunately their analyses claim roots in competing methodologies, normative (even post-

modern) for the former and positivist for the latter, and result in different prescriptions – change the economic and social structures that disadvantage the marginalised (health promotion), and improve economic wellbeing for all (population health).

Ideological battles over public-private issues relegate other topics to 'also-rans' in Australian health politics

The post-war history of health policy in Australia has been an ideological battleground between political parties over the role of the public versus the private sectors in the funding (role of citizens and insurers versus role of the state) and the provision (private medical practitioners versus state employees) of health care. This contrasts with Canada, where the 'two-tier debate' has been less important than the population health debate.

Looking to the future, there's mostly tunnel at the end of the light

There are glimmers of hope for a broader approach in Australian health policy, with examples of academics, some providers and governments, organised citizens' juries and international bodies giving a higher priority to disease prevention and health promotion than to health services. However, the future still looks dismal because existing interests in Australia – 'a strife of interests masquerading as a contest of principles' – continue to dominate, and 'windows of opportunity' – those lucky confluences of economic, social and political circumstances that facilitate substantive policy shifts – are nowhere on the horizon.

As a diagnosis and a call for change, the paper is a worthy addition to the existing stock of such exhortations: WHO's *Health for All*, Canada's *Lalonde Report,* The UK's recent *Acheson Report*. Indeed, it adds a very useful analysis, derived from Veenstra, of the potentially self-destructive tendencies of the reformists in their separate 'health promotion' and 'population health' camps.

However, as a policy analysis *for* the existing political and policy realm in Australia (or elsewhere) it falls short on feasibility, on how to get there from here, and also at times on its evidence. This criticism is likely unfair, as the intent of the authors appears to place the paper squarely as an 'analysis *of*' rather than an 'analysis *for*' the policy world. The critique, therefore,

reflects this commentator's more pragmatic orientation to policy analysis, playing the role of Machiavelli to Lewis and Leeder's Ivan Illich.

In the rest of this commentary I will first pick a few nits with the Lewis and Leeder diagnosis, although fundamentally agreeing with their premises. I will then make some modest suggestions of how we might move in a more pragmatic and gradualist fashion to the kind of health system form that reflects the ultimate function of improved health articulated by Lewis and Leeder.

The Titanic headed for the iceberg

Of all aspects of the paper, I have most concern with the 'Titanic headed for the iceberg' type of arguments. Ironically, these are precisely the arguments put forward most often by health *care* interests who are trying to gain or expand their for-profit footholds into the publicly-dominated aspects of health provision. If you can generate enough panic and insecurity among the people about future capacity to publicly fund services, you can justify (for the well-off) the disadvantages of for-profit dominated care – the inequities, the failure to control total costs, and the administrative waste of duplicated paper flows and drained-off profits. Treating the transfer of public to private expenditure for health care so blithely, as Lewis and Leeder do, ignores the fact that, whether public or private, all health care expenditures are a potential drain – an 'opportunity cost' – on a nation's wealth.

With such large stakes and powerful interests at play, it is not surprising that the rhetoric gets confused with the facts on the aging population, technology, chronic illness, and taxation burden.

The aging population

Japan and most northern European countries are already dealing with a proportion of aged in their populations that Australia will not reach for another twenty years. They have been neither bankrupted nor corrupted; indeed, most have accommodated and adapted. A series of studies have shown that the cost increases attributable to population aging will be gradual and modest on a year-by-year basis, and easily handled within projected economic growth rates. The latest data for Canada shows that accommodation seems to be precisely what is happening – over the last five years the per capita cost for health care for 75 - 84 year olds has dropped by more than 10

per cent, and for those over age 85 by almost 25 per cent. The oncoming greying horde in health policy is largely a myth, perpetuated by two groups. Firstly, providers, who *do* see a larger proportion of elderly than they used to, but that is because the younger ages are relatively less in need of health care than they used to be. Secondly, for-profit interests, who see health care as a relatively under-exploited or unavailable market.

Technology

Technological advance in health care seems to be a completely different animal compared with almost all other sectors. In most sectors it is seen as cost-reducing and productivity-enhancing – it reduces the price of cars while simultaneously increasing their quality, it replaces bank tellers and their salaries with cash machines and their 24-hour convenience, it produces and moves food from A to B using fewer people and with less spoilage. In health care we seem to see technology as only cost-enhancing. Why? There are as many possibilities to use technology to reduce costs as there are to increase costs: machine-read electrocardiograms replace cardiologists; electronic medical records replace medical record technicians, while simultaneously improving access to needed information and reducing diagnostic test duplication; telemedicine and telehealth bring care to remote areas without the need for resident doctors, and so on. Learning how to use technology as a substitute input to health care and not just an add-on will be the key to accommodating cost-effectively to its pressure on health care expenditures.

Chronic illness

Fries and Crapo first described the possibility of 'compression of morbidity' in the early 1980s. Popularised in the exhortation 'add life to years not just years to life', this position argues that as we live longer because of a variety of health care and other influences, we will increasingly 'compress' our morbidity into a shorter and shorter period at the end of our lives. In other words, we will see a reduction in the overall burden of chronic illness on society and individuals. Recent Canadian data suggest that this is precisely what is happening. Health expectancy – the number of years lived in a disability-free state – is increasing faster than life expectancy. Although there is controversy over these and other countries' similar data, such results underline that we should not treat increasing prevalence of chronic illness as an inevitability.

Taxation burden

Even if the above pressures do not come to pass, private sector proponents (and Lewis and Leeder) argue, there is no public willingness to shoulder even the current, and certainly not an increased, tax burden for public funding of health care. The data simply do not support this contention. Far from it, nearly every survey of the public indicates that the one area in which the public *are* willing to see tax increases is for health care! Indeed, Lewis and Leeder contradict themselves on this point when they quote one of the Western Australian citizens' juries which 'agreed that if taxation was to increase, guarantees were to be given that the extra revenue would be spent on the health system'!

Having dismantled all these Chicken Little 'the sky is falling' arguments, I wish to now emphasise that their integrity is entirely unnecessary for the remaining premises of the Lewis and Leeder paper. The arguments in favour of increased attention to disease prevention, health promotion and the broader determinants of health stand on their own merits. They do not need motivation from poorly formulated and ill-supported rhetoric about the imminent crises in health care. As Nicholas Timmins said in his recent biography of the UK welfare state, 'It is quite important to know that virtually every day since 1948 the NHS has been said to be in crisis, and that every year for the last 45 years morale within it has invariably never been lower.'

The grass is always greener ...

In a number of places in the paper Canada is seen as having done a better job than Australia at incorporating the population health perspective into its debates and its system; to have relegated the controversy of private-versus-public funding to its rightful lower order consideration in health policy.

While it is true that we are the home of the *Lalonde Report* and the Ottawa Charter, it is also true that the federal government in Canada, unencumbered by any significant role in health care delivery (a role reserved constitutionally for the provinces), is far freer than the Australian Commonwealth government to muse on the more abstract notions of population health. Where the rubber hits the road for the federal government in Canada is in its transfer of tax funds to the provinces. Here, in a five-year agreement with the provinces last fall, they committed to transfer

an additional $21.5 billion for health care, and a mere $2 billion for healthy child development programs. If money speaks louder than words, then the federal government has spoken adamantly about *its* priorities.

Some provinces have established citizen boards controlling regional budgets that can be used for health care and/or broader health initiatives. Prince Edward Island is the best example, where broad 'human services' budgets could be allocated and re-allocated freely across health care, income support, job creation and other health determinants. Unfortunately, these regional boards, at least in the early years, have proved good examples of Lewis and Leeder's point 'that while direct consultation with citizens about fundamental policy issues like health determinants is important, its impact on policy is constrained by the larger political context'.

In one example, a region's board had to choose between one hospital and more community services or keeping both local hospitals open. The community voiced its favour for the latter option so strongly that the regional board had to back down on its plan to close the one hospital and forfeit the new community services. In another instance, a regional board transferred surplus funds from an under-spent welfare budget to the acute care hospital; although another board, with a similar surplus, did choose job creation programs over acute care.

Canada has been, therefore, only slightly less immune than Australia to the forces of concentrated interest in health care. The political scientist Paul Sabatier has noted the important role of strong advocacy coalitions in generating policy learning and eventual policy action. The challenge for population health in all countries has been building sustainable advocacy coalitions from diffuse and loosely connected groups, all aiming to create unidentifiable non-victims as a consequence of their effective prevention and promotion efforts – the dog that *didn't* bark in the night. Contrast this with the noisy terrier of a health care advocacy coalition, comprising the concentrated interests of providers and their suppliers coming to the aid of many identifiable and marketable victims.

Machiavelli meets Ivan Illich

Hence the frontal attack appears to be failing. Health policy is not moving from financial and managerial designs of health care to citizen-guided achievement of improved population health. A population health approach stumbles on the political fixtures of electoral cycles, manageable coalitions, visible policy impacts, and identifiable rather than statistical lives.

It is not that developing or calling for a health policy, defining the function that our health investments should perform, is worthless. It clarifies the destination, and destinations are important for, as legendary baseball manager Yogi Berra said, 'If you don't know where you're going you may end up somewhere else.' This could well form the epitaph on the graves of many modern health care systems. The destination, however, tells us little about the journey.

In the absence of a window of opportunity to jump through, the current form of health care is one starting point for the journey. The UK seems to have recognised this by building its strategies on the existing structures – a revolution from within. GP fund-holding took the population where it was – visiting their GP – and in less than a decade has moved them and their providers into increasingly organised, monitored and integrated Primary Care Organisations. It is a far shorter journey now to expand the services and the approaches, and to level accountability for the broader health of the 'captured' population on these new organisations.

Another starting point is the creation of visible indices that capture both the public's imagination (just as the Consumer Price Index or the Dow Jones Industrial Average does now) and the objectives and values of population health. For all its warts, the WHO's recent world index of health system performance starts us in this direction with its integration of equity, value-for-money and responsiveness proxies into the rankings. Others, such as the United Nations Development Program's Quality of Life Index and Canadian Michael Wolfson's POHEM (Population Health Model) are moving us down the same road. The political process seems far more responsive to the pressure of such quantitative indices, catching graphically, as they do, the metaphorical clouds of a broader health policy.

I put less faith than Lewis and Leeder in citizen's juries, community consultation and public input to get us to the population health destination. We have little evidence to support the authors' contention that if we are 'better informed citizens about health and health care ... our choices can be more intelligent and ... demands for health care become more restrained than they are at present'. The public are rather reluctant rationers; as Illich stated 'society must cope with the irrational desires of its members'.

I put more faith in the power of the elite. The identification, education and recruitment to the population health mission of one or two influential figures within the political elite is likely to pay more dividends. Indeed, the roots of the $2 billion healthy child development supplement to the recent $21.5 billion health care largesse of the Canadian federal government can be traced directly to one such Canadian influential – Fraser Mustard. He had forfeited his previous broad population health mission in favour of the more targeted (and achievable) healthy child development component of population health.

These are but three approaches for starting the journey from here to there – build out from what we have, capture what we want in a marketable index, and recruit influential figures to our cause from within the elites. They are modest and gradualist approaches compared to the revolution implied by Lewis and Leeder's call for a national health policy. They are motivated and gain direction, however, from the outlines of that transformation from health care policy to health policy. Our task is to assemble enough steps from enough people that the journey will pass quickly; perhaps in the company of good companions we will arrive at our destination faster than we think.

Where to from here? The need to construct a comprehensive national health policy

A position paper by Dr Milton J Lewis and Professor Stephen R Leeder

Reviewer The Hon Neal Blewett AC, BA, MA, DPhil (Oxon), DipEd (Tas), Hon LLD (Tas), Hon DLitt (Hull), FRHistS, FASSA

I am somewhat hesitant and handicapped in delivering this comment on the Leeder/Lewis paper as I had already forwarded to the authors a detailed critique which, while not disputing the major theses, was a kind of editorial job designed to help clarify arguments and note possible vulnerabilities. In the latest version of their paper Leeder/Lewis without changing the substance of their arguments have taken on board many of these points so that their defences are now much more secure against any attacks I may mount. My comments should therefore be seen as part of that learning process which Professor Leeder envisages should pervade this colloquium.

The Titanic headed for the Iceberg

1. In his elegant and witty review of Leeder/Lewis, *Machiavelli meets Ivan Illich,* Jonathan Lomas mounts a major attack on the Lewis/Leeder initial argument that the ageing of the population, new technology, chronic illness, public expectations and a public unwillingness to pay extra taxes for health will lead to the collapse of the existing health system and compel a radical overhaul.
2. I agree with Lomas that Leeder/Lewis is too apocalyptic; on the other hand I suspect Lomas is too sanguine. This is perhaps a typical Centre-Left perspective.
    a) I agree with Lomas that we in Australia have a tendency to exaggerate the impact of the ageing of the population. European nations already have age population proportions which we will not reach for another generation. European health systems have coped well with this impact although their welfare systems are under some strain.
    b) Lomas is correct as against Leeder/Lewis in noting that public opinion surveys do indicate that people are willing to pay more taxes to get better health care. But quite what some of these motherhood surveys mean is debatable. Moreover given that positive public views on higher taxes for health are usually coupled with the insistence that the extra taxes be designated explicitly for health care – a hypothecation adamantly opposed in this country by Treasury and Finance – the political implications of these attitudes are uncertain.
    c) On another of Lomas's points – the compression of morbidity thesis – the jury seems still to be out.
    c) Yet the relentless rise in health costs over the last generation gives weight to Leeder/Lewis concerns.
        i) Over the last 25 years in every advanced society the resources going to health as a proportion of GDP have risen, in some cases dramatically e.g. in the USA, in most cases modestly.

ii) A better measure is perhaps real per capita usage and costs of medical services i.e. a measure discounting for population increases and inflation.

  - by the usage measure in every year for the last 25 years in Australia there has been a real increase in hospital separations (offset in part by efficiencies in length of stay and day surgery), in visits to GPs and in the use of prescription medicines.
  - In every year in the past 25 years there has been an increase in real per person health expenditure – an increase averaging about 25% a decade.

What appears to be happening is that Australian are expecting and getting more services and a greater intensification of services. When I recall the diagnostic powers applied to my knee in recent weeks efficiency gains through cheaper X-rays are more than offset by intensification through new technologies – ultra-sound and magnetic resonance imaging.

3. While these apparently inexorable pressures may not create the apocalyptic scenario envisaged by Lewis/Leeder, they do constitute a significant challenge for the health system, more than Lomas appears to allow. The inevitable conservative response, when confronted with increased costs and apparent opposition by taxpayers to increased taxes, is to privatise and introduce user pay fees. We are already seeing signs of this in Australia with the revitalisation of private health insurance, the private expansion of nursing home provision, additional cuts to public dentistry. Such an approach may reduce pressure on the government budget but only at the cost of greater inequities, failure to control total costs, administrative waste, and profit drain.

The anti-politics of Leeder/Lewis

1. The response of Leeder/Lewis to this challenge, which they see as more cataclysmic than some others do, reveals an a-politicism which is characteristic of their paper. They are quite insouciant about the real outcome of their scenario. It may be that "it will first be necessary for the medical care system to fail" (p. 10) – with apparently little concern for the immediate consequences that would follow. This is rather like those Marxists who sat on their hands fatalistically awaiting the inevitable collapse of capitalism. In both cases I suspect a long wait. This is not merely the absence of a Machiavellian perspective (Lomas); it is essentially anti-Machiavellism.
2. There is indeed an anti-Machiavellian, anti – political note that runs through the paper.
   a) From the early comment that "health policy has for some years been about financial and managerial matters rather than the impact of services on the health of the people" (p.4) there is a tendency to be rather dismissive of the health outcomes of universal health systems. I confess this is not as obvious in this version with a number of exculpatory sentences included, but nevertheless the tendency remains.
   b) A good example is the implied criticism on p.29 of the Whitlam government for giving priority to Medibank over the community health program, as if

given the political and medical climate of the time there was a real possibility of the Whitlam government reversing these priorities.

c) There is a wonderful mea culpa on p. 22 when Leeder/Lewis realise where there own logic and their rather dismissive arguments about national health schemes are leading them.

> "Ironically, in the context of the international retreat from the welfare state, health promoters may be forced to oppose proposals to reduce state expenditure on health care because those whose health has been harmed by systemic inequity would be further disadvantaged. Also universal, state-funded health care symbolises collective support for a moral economy which seeks to redress the effects of inequity

An Alternative Approach

1. The core of the Leeder/Lewis paper is the effort to construct a basis for a comprehensive national health policy. This, as Lomas has pointed out, is not logically dependent on the Titanic hits iceberg scenario.
2. I am sympathetic with their approach to establishing priorities for a health system, following as they do the work of the American ethicist, Daniel Callahan. Leeder/Lewis certainly do not underestimate the political difficulties of establishing such a system, indeed it is at this point that they invoke the counsel of despair of waiting for the existing health order to collapse.
3. But the Leeder/Lewis discussion of the various reformist approaches – population health, health promotion and some psycho-social hybrids at the margins – achieves no resolution.
4. Leeder/Lewis have almost too much fun discussing the guerrilla wars between these groups rather than seeking some synthesis essential to the final section of their paper.
   a) Caricatures abound partly because of a lack of definitional and conceptual clarity in this section.
      i) the health promotion people tend to be the "goodies" – normative, community-based, democratic, anti-capitalist
      ii) the population health people the "baddies" – positivist, elitist, Reagan-like trickle down theorists.
5. The consequence of this failure to seek some resolution between the contrasting, though not necessarily antipathetic, approaches is that we have no model into which the eclectic range of programs discussed in the last section can be fitted, or any set of criteria by which to judge them.
6. We desperately need some organising devices for they are a rag-bag collection: (roughly in order of appearance) Ron Phillips's 1994 national health policy proposals; Wooldridge 1996 health prospectus; WHO Europe, Zollner and Lessof, population health policy paper; WHO Europe, Marmot and Wilkinson paper on social determinants of health; UK citizen juries; Nova Scotia people assessing their health project; RACP socio-economic determinants of health project; citizen juries in Western Australia. Without adequate structures being provided by the central core of the paper these become little more than a desultory list describing some interesting projects.

Where to from here? The need to construct a comprehensive national health policy

A position paper by Dr Milton J Lewis and Professor Stephen R Leeder

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INTRODUCTION

It is 100 years since Federation and Australians can look back on considerable gains in quantity of life if not quality.

TABLE 1: A COMPARISON OF HEALTH IN AUSTRALIA BETWEEN 1901 AND 2001.

	1901	2001	Gain/Loss
1. Life expectancy men	55.2 years	75.7 years	Men gained 20.5 years
2. Life expectancy women	58.8 years	81.4 years	Women gained 22.6 years
3. Male Infant mortality	110/1000	5/1000	Saved 105 boy babies in a 1000 births
4. Causes of premature death	Pneumonia, influenza epidemics	Accidents, suicide, violence	Self inflicted injury and environmental hazards
5. Common Health problems	Malnutrition, gastroenteritis	Diabetes, obesity, asthma	Diseases of affluence
6. Mental Health Well-being	Rarely reported	Depression, eating disorders and anxiety common	A mental health epidemic?

Note: Various sources.

So is the successful Australian ‘health Titanic’ about to hit the policy iceberg, as Jonathan Lomas caricatures the argument of the paper. I must say that I didn’t read this argument in the paper. The authors don’t say that the health system is about to fail but rather they suggest rhetorically that the system may have to fail before we get the political motivation to change. The analogy might be putting children’s crossings near schools only after children have been killed by cars. I agree with the Lewis/Leeder proposition that there is a sense of unease or malaise about Australian health policy and a growing lack of clarity about it goals and values. I support the argument for the need for action now rather than waiting for it to fail.

I would like to make four points in response to the paper, mostly constructive rather than critical, namely: the missing part of the health debate, what to do about

population health, the problem with ageing and the need for value clarity and experimentation.

FIRST POINT: A SUBSTANTIAL PART OF HEALTH IS MISSING FROM THE DEBATE

We have a health development project running in Miller, a public housing estate west of Liverpool. When I offer the wonderful array of health science specialists that we have at the University, the skills that are most in demand are naturopaths for massage, aromatherapy and herbs. The response is similar at the Benevolent Society Women's Health Centre in Campbelltown. The preference is provided against a background of reasonable access to conventional health services such as GPs and Accident and Emergency and acute hospital services. But I would like to reflect on these experiences to illustrate what is a growing area of health services to which policy is completely blind. I argue that the authors must broaden their response to the question: What is health?

Some facts about the scale of complementary and alternative medicine (CAM) were recently assembled by my colleague Alan Bensoussan (MJA 1999;170:247-8):

- As far back as 1993 Australians were spending twice as much on CAM ($621 million) as on contributions to pharmaceuticals (McLennan et al *Lancet* 1996;347:569-573.

- Recent government estimates indicate that 57% of Australians and 42% of Americans use CAM (Bensoussan above).

- A German study estimated that the international market for CAM products was about $20 billion in retail sales in 1996 with a 15% pa increase (Gruenwald *Drug Inform J* 1998;32:151-3).

- USA data from 1997 shows more visits to CAM practitioners (629 million visits) than to primary health care physicians (Eisenberg et al *JAMA* 1998;280:1569-1575).

- Chinese herb imports to Australia have trebled since 1996 and Chinese medicine consultations (acupuncture and herbs) in 1996 accounted for $90 million in service payments (Bensoussan & Myers, *Towards a Safer Choice*, UWS 1996).

Roy Porter observes in a review of the history of medicine that: "…regular medicine has ceased to convince the public that it is the only, of the best, means to cure their ills" (*The Greatest Benefits to Mankind: A Medical History of Humanity form Antiquity to the Present*, Fontana 1999). Although it isn't discussed in the paper or at any length in mainstream health economic and policy debate, this is fertile territory for much dissatisfaction with the health system. Reasons for the popularity and growth of CAM derive from 'new age' post-modernism to dissatisfaction with interactions in conventional medical services as well as being patterned by different ethnic backgrounds. New work is showing that people choose specific practitioners for particular health problems and that dissatisfaction with conventional medicine does not predict more use of CAM. Regardless of differing points of view on CAM, it

is now of such a scale that it must be integrated into research and policy on the Australian health system. The proposal is hardly radical since the USA has already established a National Center for Complementary and Alternative Medicine with a budget of around US$50 (A$100+) as well as substantial research funds targeted on this area. The US Center is already producing data and debate that allow CAM to be included in government policy and decision-making.

There is prejudice and professional industrial interests to be overcome if this is to be achieved. When CentreLink employees recently were given access to massage therapy to relieve stress and promote health, there was a media outcry but the same would be unlikely to occur if it was access to a GP or a counsellor/psychologist that had been provided. The argument for inclusion of CAM in the debate has some urgency because many its practices fall outside regulatory and policy control. They are literally out of sight and out of mind. They don't trouble the Treasury government expenditure counters so they don't rate in policy! We can't afford this situation to continue given the current and growing scale and popularity of the practices. There can be no comprehensive national health policy that doesn't embrace CAM as part of the health service system.

<u>SECOND POINT</u>: WHAT DO WE DO TO MOVE THE AGENDA FORWARD?

Lewis and Leeder comprehensively review the social factors and ethical/moral debates about health placing them in the context of a new view of 'population health'. It is important to clarify differences between universal access, equity of outcome and equitable health financing which contribute in different ways to achieving better health. The simplest political trap is the reduction of issues of access to counts of waiting lists without consideration of who doesn't get onto those lists or what quality of service people receive when they get through the list.

The problem with much of these debates is that they are, as Lomas retorts, short on feasibility. The paper mentions health impact assessments and strategic community participation in health delivery but any policy program is largely implicit. I believe that these ideas can be developed further into a plausible policy program. I also agree with Dr Blewett's point that more analysis of the recent history of health policy will be an advantage in shaping this program. However the formulation the new program from the emerging research on social factors has a priority over this in my thinking.

There is as yet limited evidence about what to do about improving equality and population health or how to proceed with the current tight resource constraints. Even the best researched area of the impact of interventions in early childhood years doesn't yet yield reliable estimates of effect sizes from interventions and others areas like 'health action zone' type work are researched and evaluated in complex ways. Nonetheless experts like Michael Marmot and Richard Wilkinson were confident enough to create the WHO document 'Social Determinants of Health: The Solid Facts'. The first practical observation is that health impact assessments can be conducted around the areas identified in this review of the evidence. This might, for example, lead the Minister for Health to argue in cabinet against the distribution of education funding to well resourced private schools rather than to significantly more disadvantaged public schools such as those in the Campbelltown, Penrith or Blacktown areas. It would not assure avoidance of Wilkinson's 'relative deprivation'

trap but it would be a big improvement in health policy debates in the direction proposed by the paper.

A group of us are currently working on developing a policy document for NSW Health on 'Health and Equity' and part of the Health Council reforms including Jim Hyde (UWS), Liz Harris (UNSW), Peter Sainsbury (USyd). We decided to concentrate on five strong areas for action, namely: the importance of good beginnings, greater participation, a focus on place, relevant organisational development and new ideas. We are discussing practical ways of implementing an approach like that proposed by Lewis and Leeder such as:

- Ensuring Area Health Service CEOs 'buy into' the new agenda;
- Initiating a cultural change process for senior clinicians;
- Engaging nurses and educating them in the new 'population health';
- Requiring that new money to be spent according to 'population health' priorities e.g. community delivered services before hospital beds; and
- Refocusing existing money towards new agendas for action.

These practical priorities will be developed in the report to government due later this year. There is an excellent opportunity and a supportive environment to move the Lewis/Leeder agenda forward into implementable policy. Despite a relative lack of evidence about this 'social factors' approach there is probably a stronger base in evidence and in macro- and meso- theory than the research base that led the privatisation and competition agendas of the 1980s. While the lack of evidence remains an issue, there may never be a better opportunity than now to take on these issues in policy formation.

THIRD POINT: WHAT IS THE PROBLEM WITH AGEING?

Both the paper and the response by Lomas mention ageing as a significant factor in the future of health policy. Despite apparent disagreement it would appear to me that they agree in not over-rating the problem. Lomas is very positive on the basis of international evidence. The national trend data from the Australian Bureau of Statistics disability surveys indicates a more pessimistic picture, namely that rates of severe handicap for people 65+ increased between 1981 and 1988, flattened back to 1981 levels in 1993 but apparently increased in 1998 (Table 2).

TABLE 2: TRENDS IN RATES OF SEVERE HANDICAP (PERCENT) 65+ AUSTRALIA.

Severe Handicap			
	Men	**Women**	**Persons**
1981	12.3	20.4	17.0
1988	13.1	22.6	18.6
1993	12.4	20.3	16.9
1998	14.8	23.3	19.6

Source: Wen, Madden and Black (1995) and various ABS Disability Surveys. Note various minor adjustments can be made to previous years to account for methodological changes but these do not alter the trends.

Note: The ABS measure of disability is complex and relatively 'soft' or inclusive so it is better to concentrate on severe (and profound) handicap as indicator measures for morbidity.

As well less severe disability and handicap rates also increased substantially between 1981 and 1998. Because comparable countries are showing improvements in disability-free life expectations, there is a need for more intensive study of the burden of disease in Australia. Australia comes in second only to Japan in terms of the new WHO health life expectancy measures so it is already in a good position. New longitudinal evidence shows that healthy people can delay disability (Simons, McCallum, et al *Age & Ageing* 2000). People with lower health risk have delayed disability, less disability at any age and less cumulative disability over their remaining years. The question is what factors predicting burden can be turned into successful interventions to minimise burden of disease.

The problem with ageing parallels the social factors debate. It is not costs that arise from 'repair shop' medicine but the appropriateness of medical responses to older people's needs which is the problem. Ageing is historically new and acute care medicine is poorly prepared for its complexity and multidisciplinary nature. Comorbidity is now the norm for acute hospital admissions and even for older people living in the community. There is as yet no agreed measure and continuing debate over the very concept of comorbidity. Even more important, the health system from research to clinical practice is just beginning to think about comorbidity. A range of issues needs careful thought and resolution in relation to ageing, for example:

- Community-based care versus intensive and residential care;
- Advanced directives to avoid heroic medicine that older people do not want;
- Palliative care when health cannot be improved;
- Dealing with comorbidity as the norm in clinical practice; and
- Creating more effective, flexible and responsive transitions, residential to acute to community modalities.

Just as in the case of social factors, there is little research that helps us answer the questions we have about ageing. We know more about the ageing of the fruit fly and the nematode than about any of the issues raised above. The geneticisation of medical research is a future threat to our interest in more research on social factors and ageing. Like a Mercedes Benz car the older body is not simply fixed by replacing one bit of the plan because the whole body is ageing. Genetics simply asks the wrong question about ageing. Similarly it is the wrong question for social factors which are by definition the product of human free will and capacity for social construction. The battle will be to maintain the research investment in the areas of interest to the Lewis/Leeder 'population health' approach.

LAST POINT: THE NEED FOR VALUE CLARITY WITH EXPERIMENTATION

While the Lewis/Leeder paper needs development in terms of its practical program, it is strong in emphasizing the centrality of values to reform of the health system. The paper puts a strong emphasis on 'universal access' and 'community participation' but a low value on 'competition' which had strong support during the 1980s and 1990s. The 'universality' of access to the health system is a good starting point to examine the complexities of pursuing such values. It can be threatened by big changes, for

example if the Pharmaceutical Benefit system were to be dismantled by World Trade Organisations decisions. On the other hand it can suffer 'death by a 1000 cuts'. For example thought needs to be given to the implementation of primary health care development exclusively around GPs since there are areas with no GPs who bulk bill. While this is relatively minor, in combination with other factors it can threaten universalism.

On the positive side the Hawkesbury District Hospital development suggests the potential for innovation by government in the maintenance of public hospital services. Mindful of the level of community outrage in 1992 at the abandonment of plans to construct a new public hospital at Windsor on Sydney's outskirts, the NSW Government contracted Catholic Health Care to meet community expectations in ensuring the quality and accessibility of services provided at Hawkesbury Hospital. The contract states in part:

> *The Hawkesbury Community Board of Advice, which has a majority of community representatives, assists: … the management in delivering a range of services with the quality and responsiveness expected by the local community … and will provide advice and counsel to the Service Operator in order to achieve and maintain the standard of patient care required under the Services Agreement, to present community views and to assist in governance of the affairs of the Health Service. (PAC 1994)".*

Wentworth Area Health Service monitors the quality of care at the Hawkesbury Hospital using accreditation, peer hospital comparison and performance review for high-volume treatments. It also requires clinical services for public patients to match those for private patients and encourages community involvement. The hospital's performance must be equal to or better than the average of five NSW public peer hospitals. If Hawkesbury Hospital fails to meet quality standards for three consecutive months, it receives formal notification from Wentworth that it has three months to raise the quality of care. Failure to do so could lead to termination of the contract.

TABLE 3: HAWKESBURY HOSPITAL CONTRACTING PROCESS

July 1992 — The NSW Government announced that a new hospital in the Hawkesbury region would be owned and operated by a not-for-profit organisation.

September 1993 — The NSW Health Department called for expressions of interest from religious not-for-profits only.

February 1994 — The NSW Public Accounts Committee released its report, *Expansion of Hawkesbury District Health Service*.

August 1994 — The NSW Government awarded the contract for Hawkesbury Hospital to Hawkesbury District Health Service Ltd (a not-for-profit operator and wholly owned subsidiary of Catholic Health Care). HDHS is responsible for operating the facility, but subcontracted responsibility for design and construction to Fletcher Construction. The project was financed through debt and equity.

December 1994 — The contract was signed by Wentworth and HDHS.

August 1996 — The new Hawkesbury Hospital opened.

Source: Implementing Reforms in Government Services 1998 p.52

It can be argued in this case that apparent privatisation has increased access/universality in the rapidly growing western suburbs of Sydney. We need to be creative in the ways that we pursue the value of universalism or it will not be achieved.

More controversially for access and equity, traditional private hospital infrastructure development in Sydney now includes hospitals that are co-located with a public facility to form a joint medical facility. Co-located public and private hospitals operate at arm's length, although the current models in Sydney value the closer links to medical research and training, and shared private services e.g. pathology and radiology that these opportunities present. Such co-locations are an explicit example of two-tier health provision with easy access for those with money or private insurance and waiting lists for others. However the development of Jamison Private at Nepean Hospital in the outer western suburb of Penrith has been argued to have increased the capacity to attract medical specialists from the wealthier areas to the west and therefore to enhance the quality and range of services in the public hospital. It was arguably the only option for doing so and the threats to universality it poses pale by comparison to the absence of decent services that would not have occurred without it. It is further a valuable new employer in an area with unbalanced development, namely housing without employment.

Given clarity on the values we are pursuing, there is a need for more experimentation to build a 'population health' program. We need more ambitious experiments that are properly evaluated. The coordinated care trials have proceeded with limited evaluations. While much has been achieved more could have been achieved with a clearer agenda and rigorously designed evaluation. Citizen's juries (p 41) as proposed by Lewis and Leeder provide one useful model that deserves more work. The concern with the citizen's jury is not just that government support is a prerequisite for it to work but that it can get lost in process and loose the capacity for action, reform and change.

Andrew Mawson in Melton Mowbray UK has tried the more challenging community ownership of health facilities like hospitals. In this model the working class and multi-ethnic community directs the activities and employs the professionals. Some of the greatest opposition to this came from Government employees as regulators and health unions and professional groups. These more radical options are most likely to be taken up by groups who are so dissatisfied that they are prepared to put in abnormal efforts into achieving better health care. Prime candidates are groups like AIDs Councils and Aboriginal communities. Where such motivation exists it deserves support to move the health system towards greater community participation.

BRIEF SUMMARY

In summary, I believe that the time is appropriate for the model that Lewis and Leeder propose. More work is needed in supporting research and evaluated experiments to develop their agenda for a comprehensive health policy. However there may not be a better opportunity than the present to introduce the broader population health approach they propose into Australian policy debates. What better time than the year of the Centenary of Federation to refresh the political commitment to better health of the population. Hence, given the above comments, I commend the paper and compliment the authors on their insights and effort in promoting debate about health policy.