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REPORT OF THE INTERNATIONAL SYMPOSIUM ON CANADIAN HEALTH POLICY

Toronto, Ontario, May 8-10, 2000

Health Network, Canadian Policy Research Networks

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Contents

On May 8-10, 2000, the Health Network of the Canadian Policy Research Networks hosted an International Symposium on Canadian Health Policy. This event fulfilled one component of the Towards a New Perspective on Health Policy (TNP) project. The aim of the symposium was to test the relevance and usefulness of the TNP hypothesis as it stood at the time: "the quality of the interaction between an individual and his or her social context is a major contributor to health." Participants were asked to consider whether this way of looking at health aided the development of policy responses. This was done in light of four dimensions of international health, corresponding to four stages in the development of health policy: public health, the health care system, health promotion and inequalities in health. We invited four international experts to introduce each topic:

International Public Health Issues
Dr. Ilona Kickbusch, Head of the Division of International Health, Department of Epidemiology and Public Health, Yale University School of Medicine, USA

Sustainable Health Care Systems
Dr. Kieke Okma, Senior Policy Advisor to Dutch Minister of Health, Welfare and Sport, the Netherlands

Learning from Health Promotion in Developing Countries
Dr. Irving Rootman, Director, Centre for Health Promotion, University of Toronto

From Research into the Inequalities in Health to Public Policy
Dr. Harry Burns, Medical Director of Public Health, Greater Glasgow Health Board, UK

Following presentations and a question and answer session, participants were divided into small groups. We asked them to use the TNP hypothesis as a tool for thinking about policies that would address the issues raised by the presentation. To facilitate this process groups were given a set questions and asked to categorize their list of policies according to those directed most at individuals, the environment and interactions between individuals and the social environment.

The design of the symposium was based on CPRN's methodology of shared learning. A neutral space is provided for a small collection of experts from different disciplines and sectors to speak openly about matters of common concern. In exposing the research results to criticism, knowledge is brought to bear on the issues that are raised and debated. For a project designed to push forward our understanding of health, what counts in this process is what is taken away from the meeting. The Chair, Margaret Catley-Carlson said in opening the event, "Our views depend on where we sit. The purpose is not to find a comfortable consensus but to ask hard questions, bring international experience to bear upon issues and

consider whether the idea carrying the Towards a New Perspective project has validity for informing the next generation of health expenditures."

What unfolded over the course of the symposium is best described as two overlapping events. One was the presentation and response to international health issues raised by our four speakers, the other an engagement with the hypothesis of the Towards a New Perspective project. The former was concrete in nature and complex in substance; issues were raised that normally fill entire conferences. The latter was characterized by a rich debate over how to think about health at a theoretical level. Overall, the challenge of linking the two events proved to be ambitious.

To record the International Symposium, this report is therefore structured not according to the schedule of the day but by separating the two "events." Part one addresses the issues raised by the four presenters through abstracts or summaries of each presentation and a synopsis of the subsequent discussion. Part two gives an account of the presentation and results of testing the TNP hypothesis. Part three identifies overall themes where the two "events" came together. Drawing the report to a close is a fourth section on recommendations and the conclusion. Further details are included in a lengthy appendix which can be used as a reference guide to the proceedings of the symposium.

Part One International Presentations

Ilona Kickbusch presented to the symposium new ideas on what is happening in international public health. Kieke Okma challenged the consensus in Canada that the health care system is not sustainable. Irving Rootman presented examples of health promotion strategies in developing countries, and Harry Burns shared with us a case study of his work trying to reduce health inequalities in Glasgow.

Ilona Kickbusch – International Public Health

Presentation Summary

Ilona Kickbusch introduced the topic of international public health by drawing a picture of ways in which the global health arena has changed, offering five conceptual frames as aids and recommendations of ways to move forward. First of all, one can no longer differentiate a domestic health policy from a global health policy. While nations continue to make policies, the determinants of health increasingly lie beyond their borders. There are two schools of thought regarding globalization: negative or positive. The former focuses on economic development and the polarization of rich and poor. The latter argues that a sense of threat in rich countries will drive them towards creating a common agenda and improving global health. Second, the global health arena has changed as a result of new actors and means of political intervention. Kickbusch argued that international politics based on the nation-state has been replaced by trans-national networks influenced by a range of new actors.

In terms of problems, it is important to recognize that there are "White Knights" (international organizations, non governmental organizations and private sector 'do gooders') but also "Black Knights" such as the international trade in illicit drugs, human organs, sex, un-safe medicine, tobacco, blood and the global marketing of ill health. In terms of disease, HIV/AIDS is causing dramatic declines in life expectancy in Africa.[1] The sheer magnitude of this problem is so severe that we are witnessing a societal shift in

[1] As of 1999, UNAIDS/WHO calculated that life expectancy in southern Africa rose from 44 in 1950s to 59 in 1990s. It is now predicted to drop to 45 between 2005 and 2010 due to AIDS.

population. Tackling the spread of disease may be more difficult given the increasing privatization of medical care and growing global health care market.

In response to these developments, Kickbusch presented five different ways to frame national/domestic and global/international health policy.

- One approach is to define health as a global public good. From this perspective, health lies beyond national or private goods on the basis that it possesses "non excludable, non rival benefits that cut across borders, generations and populations."[2] The increasing threat to common resources and the international transfer of risks are forces that contribute to this way of looking at health.
- Second, there is an effort to find ways to finance global health governing structures through new mechanisms such as the Tobin tax on international financial transactions or airport taxes.
- Third, questions are being raised around the relationship of disease to development. Health and development must be seen to hold a reciprocal relationship, in which both function as investments and resources that serve to further the goals of the other.
- Fourth, ethical issues are being raised about who sets global health priorities given the range of new actors and prevalence of tied aid. Aid from major donor countries has been declining as a percentage of GDP over the last decade.
- Finally, there are attempts to define health as a security issue, such as in the USA – where the global HIV/AIDS epidemic was recently declared a national security priority and raised at the UN Security Council. This development marks a shift in the concept of security, defined not in terms of states but citizens.

To move forward, Kickbusch made proposals such as recasting international development assistance as globalized internal policy, building global health competence and exploring new financial mechanisms. She also called for support for a network-based global health governance infrastructure with a particular view to priority setting and accountability.

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[2] I. Kaul, Il Grunberg and M.A. Stern (eds.) *Global Public Goods: International Cooperation in the Twenty-first Century* New York: Oxford University Press, 1999. Published for the UNDP.

Discussion

One discusssion that ensued following the presentation took up Kickbusch's remarks about the challenge of governance. With respect to the form of accountability needed, the question asked was: who is the broker? Investment priority may not be set by countries but by funders, such as pharmaceutical corporations or the Bill Gates Foundation. Similarly, reactions to the introduction of vaccines may be based more on concern for sovereignty than health. With the private sector driving policy as patterns of investment change, more attention needs to be paid to the relationship between funders and government. In light of this, some participants saw trust in international institutions as important. They want to see the WHO in the role of leader. One participant called for players to adopt a view of "dynamic interdependence" rather than a right versus left political perspective. Similar to efforts to establish a rules-based international order through environment, food safety and trade agreements, the way forward at the domestic level in Canada is through networks such as the Federal-Provincial-Territorial Advisory Committee apparatus.

Although one participant found the division and metaphor of Knights not useful, most did and agreed that there is a need to tackle the Black Knights in a collective manner. How this could be done was less clear. It was argued that social priorities need to be vigourously defended against the domination of health priority-setting by market forces. At present the amount of money invested in research and development addresses only 10 percent of the global population since it is geared to industrialized nations.

Viewing health as a global security issue, as in the United States, raises domestic interest in addressing international health inequalities. Several participants were concerned, however, about the use of fear (ie. to antibiotic resistance, migration, HIV) as a means to inspire action. They argued that there are two reactions to threat. The Codex Alimentaire for food safety is an example of international co-operation, where a common problem leads to a common cause. On the other hand, fear can lead to protectionist measures such as bans on products and migration. In their view, "you hardly ever scare people into the right answer." Others argued that a threat has to be perceived in order to gain public support. Pointing to the consequences of a failure to act now can be useful.

Another topic discussed was how Canada relates to global international health. Several participants voiced a need for health policies that respond to international problems. There was widespread agreement that Canada's "two silos" of domestic and international health policy and research are an impediment to addressing new public health issues. Overcoming this separation is necessary. At minimum, international public health policy should not be excluded in national research. At best, new institutional structures such as the Canadian Institutes for Health Research (CIHR) would take the opportunity to include an international public health component.

How Canada should participate and contribute to global health issues and governance structures also needs to be addressed. Finding where new players such as NGOs and foundations interconnect is important. One participant thought that the idea of health as a global public good, and as a global right, may be an important organizing theme on the domestic front. Kickbusch's conceptualization of sovereignty as a limited power in the face of globalized health issues has ramifications for Canadians' sense of health security. Promoting this idea may raise awareness that the effects of international health inequalities are not isolated to certain countries or regions of the world. Domestic objectives, for the health and security of Canadians, would then include addressing inequalities abroad. Protecting the health of Canadians requires protecting the health of people everywhere.

Since most had agreed that Canada has few needs from the rest of the world, the question is then: "What can Canada give?" Kickbusch argued that internationally, this country is perceived as a trusted nation that stands for certain principles. It was suggested that Canada could act as an international champion by declaring health a global public good and creating a structure similar to the "Global Health Council" in the United States.

Kieke Okma – Sustainable Health Care

Presentation Abstract "The sustainability of health care systems: An international approach to Debrah Stone's Chocolate Cake Problem"

There is no doubt that the famous Lalonde report of 1974 has served as an inspirational source to other industrialized countries in reframing their health policies.[3] But in most cases, this shift has not resulted in dramatic changes in the existing distribution of services, decision making power and financial risks.[4]

The expression "the sustainability of health care systems" suggests a universally accepted and applicable concept. There is reason to question this claim when analyzing the term sustainability. Does it mean financial affordability, public support, good governance, capacity to absorb external shocks and innovation, or, is the phrase posed in legal terms? This discrepancy in meaning suggests there is no universal 'sustainable' health care model.

Second, in spite of widespread debate, there has been little actual change in national health systems.[5] Health care systems share common welfare principles, face common pressures, and have comparable policy reactions. There is convergence in international policy rhetoric, but divergence in actual experience (Pierson, Ranade). In spite of trends of globalization, health care policies remain mostly a local or parochial affair. The call for retrenchment of government in the 1980s (in Canada) did not translate into reduced government influence in health care services.

There is an important difference between learning *about* versus learning *from*, in the process of cross-border learning (Marmor, 1995). Not all information about other countries can usefully serve as a basis for drawing policy lessons. Countries use the same terms with different meanings, or different terms for the same concepts.

Further, there is need to distinguish between *procedural* and *substantial* policy learning. The first refers the process of policy making, the capacity of system learning and particular features of the policy, such as fiscal and legal systems. Diverging policy environments may explain the lack of convergence of universality in health policies.

Finally, on substantial learning: first, policy principles do not easily translate into practice. On the abstract level, there usually is wide public support for principles such as

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[3] M. Lalonde. *A new perspective on the health of Canadians: a working document.* Ottawa: Information Canada, 1974.

[4] JW Bjorkman and C Altenstetter (eds) *Health Policies, National Schemes and Globalization.* London: MacMilan, 1998.

universal access, equity, or solidarity in sharing the financial burden. But such general support does not automatically lead to support for social policy measures. This is also true for policies aimed to improve the health of the population. It is hard to object to such aims, but it seems still harder to translate that policy goal into actual policy measures, or to shift the emphasis within health ministries from the administration of funding and contracting arrangements or quality control towards 'healthy policies'. The 'healthy policies' sometimes are somewhat short on actual policy measures for central governments. How do they affect the 'mainstream' policies for allocating budgets, risks and decision making powers in health care?

The background papers to this seminar show that the two 'models' of health-oriented policies: a) changing individual life styles, and b) affecting health determinants, have had limited success. One of the interesting puzzles is: what makes us think that we will do better in affecting the way the individual interacts with his environment?

This finding should make us hesitant to advocate government policies requiring major system change. The framing of policy goals does not equal the implementation of change, and governments are not always the main agents of change.

Finally, all such warnings are not to say that there is no need for change whatsoever. But the claim that the current arrangement can and should be replaced by entirely different ones is not convincing. Such a claim requires convincing arguments including proposals for a coherent set of feasible policy measures and policy instruments. Maybe, discussing such policies will show that they do not really require a dramatically different policy model.

Discussion

Given the recent attention to health care in Canadian politics, participants were keen to discuss what was driving this issue to the top of the political agenda. Some interpretations of the current "health care crisis" saw it as a crisis of confidence, the concern with waiting lists emblematic of a loss of trust. Participants agreed that concern over health care is largely media fed and symbolic. Nonetheless, how citizens interact

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[5] For example, see TR Marmor and R Klein in the "Report of the First Four Country Conference," Amsterdam, 1995.

with the system is important. To show this, a need was expressed for information-producing bodies independent of government. Their analysis would address the lack of confidence in the health care system. Okma offered the view that you need to look at how government policy is perceived.

Others were less certain that the problem lay only with confidence, noting that there has been massive change in recent times that has not been for the better. It is for this reason that questions of the social safety net and welfare state are being raised through concern about the health care system. Okma argued in response to the focus on waiting lists that they are a management problem. What is unfortunate is that this isolated debate occurs without any link to consideration of the country's overall expenditure on health care. It was asked whether this "crisis" is one of health care or of politics. Glouberman remarked that one of the pressures in Canada is that health care is an important part of the federal system. To move away from being captured by "crisis," one participant stated that the question to ask is whether the health care system is resilient In other words, can necessary changes be made without breaking the system? It is not crisis or sustainability we should speak about, but "changeability."

This led to a conversation on what has changed since the implementation of universal health care. Sholom Glouberman argued that in Canada health care is considered part of public infrastructure, in the UK health care is considered a service and in the US it is veiwed as a commodity. In response to these models, different views emerged regarding whether health is a commodity or a public good. One participant argued that we need to view health and health care broadly to account for private business in health. This would acknowledge financial exchange within the Canadian health care system through mechanisms such as the sale of services. A wide range of industries, such as weight loss, fitness, lifestyle, drugs, massage therapy and nutrition, are tied to health. In what some may consider a paradox, these industries reflect a willingness by consumers to spend money, while at the same time citizens refuse tax increases. The border line between public and private is thus not entirely clear when we compare individual investment to collective investment. It was noted that health industries also reflect a desire for choice and determination in health, external to medical

authority. A cautionary note was raised, however, that the medicalization of society should not be mixed up with commodification, which is a different level of debate.

It was argued that a change in the role of health in the lives of citizens is significant to the health care system by changing expectations and the level of service provision. Originally, health care insurance was intended to cover catastrophe. The system was designed as a form of income protection to prevent a family from going broke to pay for the treatment of a hospitalized child. To provide health services beyond this level makes it difficult to know where to draw the line between necessity and excess. Rising expectations with respect to health drives up health care costs. This is a new challenge to the original premise of the public system.

A question posed in response was whether consumer demand or evidence drives health care services. One participant asked what percentage of health care services are offered on the basis of systematic evidence? Is this the guide used to determine where to cut budgets when politicians are pushed to respond to expectations? It was noted that there is a need for investment in this kind of research. Several participants argued that evidence-based decision-making was essential to guide medical intervention and establish a professional way of setting priorities. Yet, one participant told the story of a doctor who recommended breast screening for cancer only to the narrow range of women considered at-risk. He received death threats for basing his decision on evidence. Similarly, others noted that legal threats contribute to a tendency to prescribe more tests, especially high technology ones such as fetal monitoring and CAT scans, “just in case.” One expert offered the view that caution is required in making statements of opinion rather than fact. He argued that the debate we should be having would address the question of “at what point in the calculus do we draw the line?” Rights to access health care were therefore pitted against evidence over where the risks lie and the power of experts versus consumers to make decisions. Public systems are strained when some people want and are prepared to pay for what they deem necessary. Trust in medical authority and different knowledge sets underlie this area of conflict.

Another aspect of the public-versus-market discussion was the articulation of a need to examine how different views influence transnationalism in health, for example, American pressure on the WHO to adopt a consumer driven model. In response, it was

noted that the World Bank stated in a report that the market did not work in health care. The point was also raised that the move towards deinstitutionalization shifts the care burden from hospitals to the community, specifically families and care givers. Unless money is sunk into the hospital sector, a real crisis could result. There are tensions within the system, for example between regional health authorities and global budgeting at the provincial level. The capacity for local decision-making, questions of allocation of resources and need for accountability and transparency were raised along with the question of whether government will take responsibility. Okma emphasized in response that public policy needs to be viewed, like politics, as a game.

Two exchanges among participants linked health care to other international health topics. Building upon the notion of health as a global public good from the first presentation, there was a debate over decentralization. This was seen as positive for allowing greater local control. But it was pointed out that where privitization occurs at the local level, health may cease to be a public good if access is limited as a consequence. In practice the concept of health as a public good faces challenges when policymakers move from principles to delivery systems. For example, with respect to the principle of access, the question that remains is: how much and who decides? On a separate note, a participant commented that the way in which the system delivers health is broader than the provision of medical services. The health care system also provides good jobs (to members of minority groups in particular) which is a contributor to health. Recognition of this role provides the basis for arguing that health needs to be seen as a productive – rather than draining – sector. This claim provoked questions around working condition variability among different sets of health care workers. Finally, a participant stated that there is value in studying countries other than the U.S. and U.K. such as Japan, Sri Lanka, Sweden and Cuba. Noting that Japan studies other countries rigorously, Canada should do this in a systematic and serious way, starting with health indices.

Irving Rootman – Learning from Health Promotion in Developing Countries

Presentation Abstract

The field of health promotion was born as a consequence of the release of A New Perspective on the Health or Canadians by Marc Lalonde in 1974, and Canada has played

a major role in its development internationally by, among other things, hosting the First International Conference on Health Promotion in Ottawa in 1986. The conference issued the Ottawa Charter for Health Promotion which has become a guidepost for health promotion throughout the world. This document defined health promotion as "the process of enabling people to increase control over, and to improve, their health." It identified five action areas for health promotion; building healthy public policy, creating supportive environments, strengthening community action, developing personal skills and reorienting health services. Although health promotion *as a field* has been primarily adopted in more developed countries, it is often seen as part of primary health care services in developing countries. This paper attempts to identify what we have learned from developing countries that might be applied in Canada by considering several examples or cases of health promotion initiatives focused on *individuals, environments* or *interactions* involving both.

An example of an initiative focused on *individuals* is a recent project in Bangladesh to encourage consumption of dark green leafy vegetables among young children which employed traditional and non-traditional communication channels (Hussain, et al., 1997). Among other things, it was found that the most effective channels were "traditional." For example, direct personal contact was more effective in reaching mothers with low literacy and SES. Possible lessons for Canada are the need to take culture into consideration in developing health education and communication campaigns and the importance of interpersonal communication, especially in the case of low literacy and SES groups.

An example of an *environmental* initiative is a project associated with an African federation popularly known as Naam. This is among the most successful of the world's grassroots movements for mobilizing people to protect and restore national resources in an area degraded from overuse (Durning, 1989). A specific case of a Naam project in the Sahel region of South Africa illustrates the great success which community groups in the developing world have had in addressing seemingly insurmountable problems that disrupt established ways of life. These successes teach us that community groups can accomplish phenomenal cooperation and support for their governments.

Two examples of *interactive* initiatives cited are the Shanghai Work Health Promotion project (Chu, et al., 1997) and the Integrated Radio Communication Project in Nepal (Storey, et al., 1999). Both suggest that *interactive* initiatives are more likely than *individual* or *environmental* projects to have substantial impacts. Lessons for Canada from the first project are: workplace health initiatives can work in large organizations and different cultural contexts; staff participation is critical; they should be integrated into company management; and they should be comprehensive. Lessons from the second are: try to link project components; match programs with evaluation designs; use evaluation for multiple purposes; involve research staff from the start and regard impact evaluation as the first step to future efforts. It was noted that increasingly, developing countries appear to be undertaking interactive interventions rather than those focused only on individuals or environments.[6]

Discussion

Given the nature of his presentation and the question posed to small groups, the discussion that followed Dr. Rootman's presentation focused on the TNP hypothesis. In response to the question "What must we do to increase the health of the population through the lens of the individual, the environment and the interaction of individual and environment," discussion groups arrived at policy mixes (see Appendix A).

Comments regarding this topic were wide ranging. One group noted with respect to policies directed at individuals, that some citizens with problems such as unemployment are medicalized inappropriately. Diagnoses need to be applied judiciously to prevent overuse of health care without denying services that can lead to important life changes where health problems are biological. Another group noted that health problems are complex. The example given was of infectious diseases such as tuberculosis where access to health care is important but can be limited for the poor and women in certain countries. To ensure that people can interact with their social

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[6] References: Chu, C., Driscoll, T. and Dwyer, S., (1997), "The health promoting workplace: An integrative perspective" *ANZJPH*, 21(4), 377-385; Durning, A.B.(1989) "Grass roots groups are our best hope for global prosperity and ecology" *Utne Reader*, 34, 40-49; Hussain, A., Aaro, L.E., and Gunnar K. (1997) "Impact of a health education program to promote consumption of Vitamin A rich foods in Bangladesh" *Health Promotion International,* 12(2), 103-109; Storey, D., Boulay, M., Karki, Y., Heckert, K., and

environment effectively and use the resources they have available to them often requires a greater understanding of social relations. For example, family planning efforts in Afghanistan must be informed by knowledge of women's inheritance rights. Inconsistent pressures from different authorities result in program failure.

Integrating environment into the health sector was identified as a challenge. To resolve this, one group proposed that health care and health promotion be seen as social policies. This may offer a route for health policy makers to move into non-health policy areas such as unemployment. Another participant commented that there are no "pure" answers to health problems. Health is embedded in a range of social functions. Policymakers thus need to remember that health is not the most important thing in everyone's life.

Another point raised was whether programs were aimed at moving everyone on the inequalities of health gradient or only those at the bottom. This raised two points of debate: first, questioning the degree to which programming in health should and can be directed at flattening the gradient; and, second, questioning how much the gradient can be flattened to serve equity.

Dr. Rootman commented at the end that the quality of discussion was high, especially around the topic of interaction between the individual and the environment. The TNP hypothesis was useful for opening up new thoughts on health promotion. He pointed to participatory research as a tool to encourage interaction and noted that ethical issues require attention. Spirituality is an important factor in many cultures and who has the authority to change culture is a question donor countries such as Canada needs to pose when designing international health interventions.

Harry Burns – From Research into the Inequalities in Health to Public Policy

Presentation Summary

Karmanchara, D.M. (1999) "Impact of the integrated radio communication project in Nepal, 1994-1997," *Journal of Health Communication,* 4**,** 271-294

This presentation gave Canadian participants an opportunity to examine how a city in Scotland is trying to alleviate inequalities in health. Dr. Burns opened his introduction to the topic of inequalities in health by showing that a ten-year gap in life expectancy exists between affluent and deprived citizens of the city of Glasgow. The powerful disparity across the city has historical roots in the nineteenth century. John Strang, the Director of Finance for the city of Glasgow raised the issue of the health of the deprived in 1861. Water supply and sanitation systems put in place towards the end of this century did help to reduce the infant mortality rate. It was not until 1911 that specific funding was targeted to tackle the problem of tuberculosis. At that time, Member of Parliament George Barnes argued that a start ought to be made in tackling phthisis, "not by academic consideration but by blundering in to it and getting something done." Rather than giving money to doctors, money was spent on sanatoriums. The city of Glasgow built hospitals then instead of houses, keeping in place the social conditions that predisposed citizens to infection. Not until the 1950s did tuberculosis begin to diminish when the population was moved from overcrowded tenements to new housing estates. A new urban slum was created, however, by bad town planning. Turning to current problems, Burns pointed to evidence that it was 110 years before infant mortality among the deprived fell to the level of the affluent. This is a reminder that health improvements are unlikely to happen quickly.

To answer the question of what should be done to narrow the mortality gap, Burns surveyed the positions of Richard Wilkinson, Antonovsky and Everson. Through a series of graphs, evidence was presented to illustrate the correlation of material deprivation with negative health behaviours and higher mortality. On this basis, Glasgow could take Wilkinson's finding that it is not total wealth but the distribution of wealth that produces good health, and use it to attempt to redistribute income from rich to poor. The "redistributionist" approach is rejected, however, because governments are unwilling to increase taxes. Turning to another possibility, Burns presented Antonovsky's arguments around stress and Everson's evidence that hopelessness is correlated with risk of death. Burns argued that consistent psychosocial factors, that enable positive emotional states and successful stress management, are at least as important to health as income redistribution.

Glasgow's strategy, therefore, is to use the concept of the life course to target interventions at key points in the lives of young people. The intention is to strengthen their ability to make sense of the world and take control of their lives. To accomplish this, the mechanism chosen is intensive home visiting targeted at deprived areas. Parenting skill advice is offered and all women who are pregnant receive daily visits. Evidence to support the focus on early years comes from studies done in the United States that demonstrate nutrition and family income as factors important to health. Burns argued that if children possess an internal locus of control that allows them to handle stress, they will see a future for themselves.

Discussion

Glasgow's problems represent the unintended consequence of economic change. In terms of effect, the end of the Industrial Revolution in the United Kingdom is analogous to the end of the semi-nomadic, subsistence hunting and fishing economy of the First Nations in Canada. In both cases, it is the generations that follow who suffer the consequences of a deprived community. Those who have done well from Glasgow are those who left. Consequently, the community has no role models of citizens who have broken out of the cycle of poverty.

Several participants questioned Burns on the choice of health visitors when socioeconomic factors appear to hold the strongest correlation to poor health. One asked his view on the debate between a neo-material versus psychosocial view of health. Not all participants were convinced that tackling the latter would suffice to alleviate inequality without tackling the former. Support was expressed instead for the model in one of Burn's examples where the effect on family income from a negative income tax programme led to improved scholastic achievement in children.

It was argued that young people in poor families need protection and opportunity. In the United States the Head Start program for children emphasizes child protection rather than development. Glouberman added that young people require enough resources to have a wide scope of activity. It is not only the absolute position on the gradient that analysts should be concerned with but also the relative position. Health policies are needed that attack all strands, not merely lessening the disparity of longevity without

addressing growing inequality. Others agreed that less ideological positions are required along with the ability of politicans to talk about more than child development.

It was also noted that the health visitors program in Glasgow is universal, avoiding an implicit stigma attached to the presence of the visitors. This provoked an exchange on the value of the universal programs of the post-war period as opposed to the targetted ones of the 1980s and 1990s. A question raised was whether the loss of universality results in the loss of real impact. Is the objective to pull up the bottom of the gradient only? How can the curves of the inequality gradient be made flatter?

Another participant noted that the program to address inequalities in Glasgow had not been evaluated yet. It is also resource intensive and relies upon trust between clients and health visitors. This is due to the fact that government workers have an obligation to contact other authorities to remove children from clients' homes if what they observe is regarded as a threat. Burns admitted that the program of intervention using health visitors is based on intuition leading from scientific evidence of the problem. It will be three years before evaluation can take place. Based on the knowledge that social circumstances are linked to biological pathways and working within the parameters of political opportunity available with a Labour government and new Scottish parliament, this is what they chose to do. With respect to evaluation, two other comments were made: that evaluation of health behaviours with respect to childhood development needs to be longer term, and, that there is a need to demonstrate success in different ways.

In response to Burn's idea of a locus of control, participants added that respect rather than materiality or meaning is important. Another view was that autonomy and control are important contributors to health, arrived at through striking a balance between dependence on others and independent action. Independence thus needs to be understood as interactive rather than the ability "to be an island." It is, rather, the capacity to walk away from hazards such as an abusive relationship. Such action is made possible by the knowledge of social support in making that decision. Another participant added that the concept of smart risk-taking fits this understanding of independence. The aim of the kind of intervention chosen in Glasgow is to teach people to make sense of the world around them at a young age by giving them role models and associations.

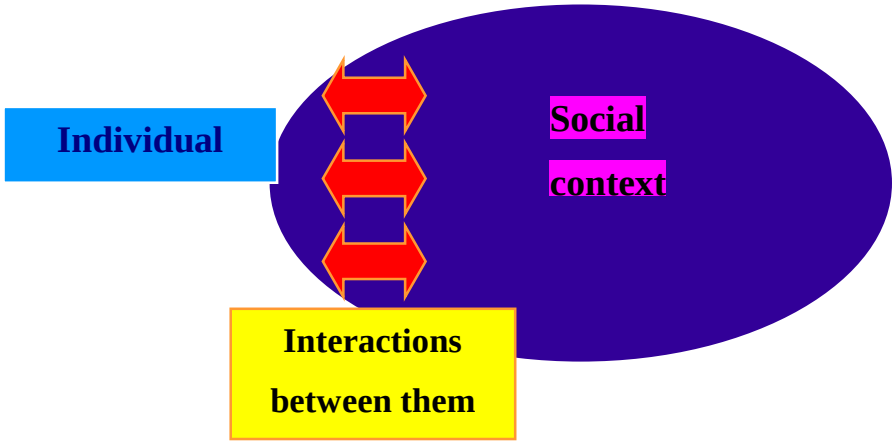
Participants mentioned a dearth of ideas on how to implement policies that address the inequalities in health. In the case of the Glasgow model, breaking the cycle of poverty was identified as necessary and worthy of investment. Resiliency and smart risk-taking are key ideas that emerged and were repeated in this discussion. Noting that resources are needed to be resilient, a participant argued that survival requires creating an environment in which people can flourish. Among deprived (and other socioeconomic) groups, people will then be the agents of change.

Part Two Towards A New Perspective on Health Policy

At the start of the symposium, Sholom Glouberman introduced participants to the work of the *Towards a New Perspective on Health Policy* project. He argued that health policy development is presently stalled by disagreement about evidence, conflicting interpretations by different groups and policy problems. One way to break this logjam is through a new approach. The project may help by offering the following hypothesis:

> The quality of the interaction between an individual and his or her social context is a major contributor to health.

This was depicted as follows:



Conceptualizing health with a focus on interaction places current work on inequalities within the context of broader approaches to health and social policy that have undergone change since the 1970s.

Over the course of the century and earlier, government investment in health has evolved in a pattern that can be seen as four building blocks. First was the implementation of public health measures such as sanitation, inspection and public health nursing, second, the enactment of universal health care coverage and third, the introduction of government sponsored health promotion programs. Research into inequalities in health suggests that a fourth block of health policy is emerging. Each of these speaks to a different health related question:

What must we do to keep people healthy?	*Public Health*
How do we diagnose and treat people?	*Medicine*
How do we improve the health of the population?	*Health Promotion*
Why are some people healthy and others not?	*Inequalities in Health*

Each block focuses on different aspects of health, introduces new ideas and has taken a long time to implement. Another similarity is that the causal efficacy of each is in dispute. Taken as a whole, the four blocks build on each other by serving as prerequistes with a cumulative power accompanied by flatter health gradients.

Current research centres upon the inverse relationship of morbidity and mortality to socio-economic status (SES). Researchers provide different accounts of the relationship between SES and health along a left-right political spectrum. The argument of the right focuses on individuals and the freedom of the market. Although inequalities may persist, it is argued that general prosperity will affect everyone. All that is needed in addition is a safety net for the worst off. The political left, on the other hand, focuses on the social environment. This perspective argues that reducing inequalities not only improves the health of the least favoured but results in an improvement of health of the whole population.

Another approach looks at how ideas about physics and nature are changing. An understanding from physics that more information does not lead to more certainty, and that we cannot completely control nature, shifts our way of thinking about the relationship between individuals and social context. This is how we arrive at the hypothesis that health emerges from the interaction between the individual and the body with the social and physical environment.

Addressing how the hypothesis applies to policy, Glouberman suggested that policies can be divided into three groups:

1. those that focus on the individual and the body
2. those that focus on the (social and environmental) context
3. those that focus on the quality of the interaction between the two

Health promotion efforts, such as social marketing campaigns to reduce smoking, fall into the second. Using the framework, it can be seen that education is individual, laws against smoking in public spaces are environmental and changing public reaction to

smokers focuses on interaction. Universal health care can also be divided when it is viewed as medicine and a valuable resource that contributes to people's sense of security. The five principles of the Canada Health Act can be separated as follows:

	Individual	Environment	Interaction
Universal Health Care	Diagnostic and treatment services	Comprehensive Public Universal	Accessible Portable

Given that the first two sets of policies have been tried with a positive effect in many cases, policies aimed at interaction can link them and create further gains. By making these distinctions, we can arrive at best policy mixes with all three to strike a balance and flatten the gradients.

Response to the Hypothesis

Following this presentation and the next day, participants engaged in an open conversation on what changes when health is viewed through the lens of interaction. In small groups, the hypothesis was considered in relation to each one of the four international health topics. Two reactions to the hypothesis emerged over the course of the symposium. One response was to the ideas and concept of interaction between the individual and their environment as a way of looking at health. A second response was to reject the categorization of policies into a framework of boxes. Each of these will be considered in turn.

Interaction

Immediately following and throughout the Symposium, consideration of the TNP hypothesis provoked discussion around the concept of interaction. Participants noted that interaction between the individual and her/his social context can be positive or negative. Terms that could be used to describe the arrows between the individual and environment in any given situation are wide ranging: enabling, agency, sense of the world, sense of worth, coherence, empowerment or damaging, hopelessness, peer pressure, failure to cope. It was noted that where Glouberman uses interaction, Harry Burns uses the

terminology of a sense or internal locus of control over one's destiny. Along these lines, enabling was a concept identified as fitting well with the idea of interaction. Policies that enable people to use their resources put them more in control. Another participant offered that thinking needs to be understood as social rather than private. In support of the importance of interaction as a determinant of health, an example of interaction given was of Vietnam Veterans who became addicted to narcotics in Vietnam where coping mechanisms were sought and drugs were inexpensive. When back in the United States, the addiction subsided when men could lead healthier lives. The robustness of their interaction with their environment in this case was the key to their health. That interaction is thus a determinant of health, and policies that "enable" people to interact positively should result in good health.

Several participants were optimistic and supportive of the hypothesis based on their view that interaction was built into the health promotion model of the 1980s. One participant argued that health promotion has been preaching interaction for sixteen years. In probing the web of causality that creates health, health promotion has pointed to social networks and settings - which are forms of interaction – as critical to health. Sociological literature examines interaction as well. Cultural change, supportive environments, personal skills and peers are factors cited in the Ottawa Charter that can be seen as implying interaction. Health promoters have tried to measure whether it is the number of people or the quality of interaction that is important. From this point of view, isolating interaction as an independent variable will reinforce its significance. One participant stated that a small policy shift for a large population could have a significant impact on overall health.

Framework

In addition to questions, small discussion groups that met following each presentation on the four international health topics, were asked to set lists of policies into the framework below. The purpose of this exercise was to test whether clear distinctions could be made between policies that focus on individuals, environments and interactions. Secondly, the TNP team wanted to know whether policy mixes could be generated that provide a balance between the three.

Individuals	The Social Environment	Interactions between Individuals and the Social Environment

It was hoped that taken together such a set could reasonably be expected to maximize our resources and flatten the gradients. In undertaking this work, participants were thereby asked to consider whether the framework helps one to think about the issues important to each of the four international health topics; public health, sustainable health care, health promotion and inequalities of health.

There were varying degrees of success with this exercise. Some groups found that they could set policies into the framework given the issues of a particular international health topic. These are attached in Appendix A. Other groups did not have time to complete the framework and chose to discuss issues instead. Overall, participants stated that they found it difficult to fit policies into the framework. Confusion was expressed around what should go into the box – what fits where and why? While the instructions identified health policies, participants found it unclear as to whether the model ought to be filled with examples of health problems versus health outcomes, health inputs, determinants of health, values, principles, policy consequences or policy instruments. A further confusion came out of the temptation to invent interactive policies from the individual and environment policies. Some questioned whether the interactive element was buried within the individual and environment cells. Others argued that interaction is not intended to replace policies aimed at the individual or environment but to reinforce the other two. Misunderstandings arose between what currently exists and what policies could exist in the future using this framework. Different interpretations of what was focused on the individual, the environment and the interaction between the two also emerged in the discussion groups.

In a discussion specifically regarding the framework, participants asked that researchers think more about what interaction is in order to clarify the three categories. Other questions, suggestions and comments raised included:

- Interaction is the web of causality; interaction is inevitable, what counts is the quality of interaction: what constitutes high quality interaction and how can we improve it?

- Find a way to manage the breadth of levels from micro to macro; the scale of interaction is important, be it individual-global, individual-family, etc.
- Individual and environment policies come to mind; the third category could be an outcome measure of the quality of interaction between the first two for any policy.
- A cautionary note not to try to push everything into one model if it doesn't fit there.
- The framework needs more items to be static; there were too many variables to focus on the interactive category
- Does a political ecology approach fit the idea of interaction?
- Need concrete examples of how the hypothesis is relevant to problems in Canada, similar to the way the Glasgow case presented by Harry Burns connected theories of health problem causation to action.

Criticisms of the framework challenged the premise that health policies could be divided into three categories. Upon reflection it would appear that the strength of the hypothesis – in calling attention to dynamic relationships – was lost in the design of the exercise. By using a framework with cells to fill in, another box was produced. Thus, the problem that arose lay in the tool used to explain the hypothesis. Using arrows, rather than boxes, to represent interactions would have been a more accurate and useful way of depicting the hypothesis.

At another level, not all participants were convinced that there was a need for a new theory of health and therefore of the relevance of the model. One participant argued that an analysis of the politics of specific cases, such as Glasgow, would be of greater value. This coincided with another participant who asked where an understanding of political economy would fit in the hypothesis. These concerns questioned the capacity of the hypothesis, as presented, to effectively guide policy. Some groups wanted evidence that a lack of success has been due to a failure to focus or recognize interaction. Out of some frustration experienced in using the framework, participants began to question the problem the hypothesis sought to address.

Participants were nonetheless willing to consider the hypothesis and engage in the debate it inspired. Many participants commented that the work done over the two days was stimulating. While mixing international health issues with theoretical discussion was unfamiliar and challenging, many stated that this melding of separate worlds was

desirable. The hypothesis gave a broader picture through which to consider concrete problems. One participant expressed the view that the ideas of the TNP project "felt on the verge of something big." Working those ideas through requires patience and time because they involve long-term thinking in a context geared towards finding short-term, quick fix answers. Others noted that the quality of the discussion was high and breadth of issues covered wide. Although the goals of the symposium appeared perhaps too ambitious, participants thought that the attempt to do something unique was worthwhile.

Part Three Overarching Themes

Inequality and Health

One theme that emerged in discussion addressed the correlation of socio-economic status to health. Within the topics of international public health and health promotion, inequality was raised as having effects that are no longer isolated. How to alleviate these effects and promote other health practices is unclear. For health care and research on inequalities, the question asked was, "To what extent do we want to alleviate health inequality through redistribution? By 10 percent? All?" It was pointed out that we have come to accept a degree of inequality in many areas. Moving from the principle to policy requires addressing the cost of equality and looking at the problem in terms of the efficiency of the distribution of resources. From this perspective, framing the question of inequalities as a relationship is legitimate in general terms but not helpful when looking at particular populations whose health status is remarkably different. Another rejection of the relationship was the assertion that this is just a reiteration of the knowledge that people at different points in the socioeconomic scale respond to policy differently. The ability to use policy is based on socioeconomic status, hence, policy must be different for different groups.

Sholom Glouberman spoke to these views by arguing that our initial inclination is to think about people at the bottom, but we should speak to the continuum. It is important to remember that we are not at the top; our health status is worse than others. It is hard to think of this as inequality because we have the basics and enough security. But, our health status should be equal to the top. More resources could be given to individuals or to social contexts to flatten the gradient. But, research by Everson and others points out that while the mere possession of resources is necessary, it is insufficient. Resources directed at individuals and environments may be present but not result in health. It is necessary in addition to resources to look at interaction. Robust interactions are developmental and poor interactions tend to be harmful. To address this, he argued that we need to start making explicit a component that has been tacit in policies for a long time. This enables us to think about policies in a different way.

Policymaking and the Role of Evidence

Another recurring theme throughout the Symposium was how health policy is made. This emerged from a general concern that certain health problems were not being adequately addressed. How to get issues on government agendas and move them from rhetoric to sustained funding for programs was a recurring question. It was tied to debate regarding the role of evidence. Participants asked what constitutes evidence, how much evidence is necessary and what the role of evidence is relative to other influences on decision-making, such as politics.

One point of view was that consumer demand and expectations – particularly for health care - rather than evidence, drive policy implementation. If you examine how policy is really made, it is clear that resisting the pressure of meeting expectation is difficult. This is a problem for policymakers, who need to proceed on the basis of systematic evidence, particularly where interventions are not economical. There was widespread agreement that an evidence-base is necessary to make informed decisions. One question raised, however, was how much evidence is necessary. There may be a need for a threshold for evidence, marking a point prior to which more research is conducted, after which research is deemed adequate to form the basis of policy. Another participant responded that there are different degrees of evidence required. Informing business leaders that there is hunger in Canada is more powerful than evidence building. Creating new mental maps or showing something new - through the hypothesis of the TNP project, for example - is another way to influence policy in the long-term. This kind of work is a two-generation task.

Critical of the emphasis on evidence and perception of evidence as neutral, some participants argued that in cases where different ways of measuring a health problem exist, the set of numbers are used becomes a political decision. Another remarked that public health happens without good evidence. One expert raised the question of what constitutes evidence. This person argued for an examination of what evidence passes and what does not. In their view, social science research methods are not judged on an even playing field with medical science. Randomized controlled trials are accepted, where other methodologies that look at a broader context, rather than isolated elements, are not

accepted. Reliance on evidence should therefore be judicious given the influence of powerful actors such as the scientific establishment and use of numbers by the media.

In Harry Burn's case in Glasgow, the public health department found it necessary to use the policy hook of biology to get the money. Social circumstances were linked to biological pathways to show the kinds of physical health problems that result from the conditions of poverty. What was also critical to the use of science was attaining the support of doctors. Once the medical profession is convinced, the effort to address inequalities gains a powerful ally. In his case, physicians supported the idea of improving the slums of Glasgow once it was proven scientifically that social change decreases heart disease. This group of professionals can resist social arguments such as health promotion, but not scientific evidence. Having them on side is very important because politicians will not dispute their authority.

Participants expressed interest in the use of biological evidence as a strategy to get on the political agenda. It was noted that Fraser Mustard's work showing biological pathways in the development of children has achieved success in bringing attention and some funding to programs that aim to improve the well-being of Canadian children. Thus, some participants argued that medical evidence is required to grab politicians interest and sell an idea to the public. Asserting truth claims based on scientific evidence and pointing out long-term damage to the population strengthens the argument that something needs to be done. It was argued that any policy program must be evidence based, have an economic return and be ethical. Biological evidence is therefore the type of evidence that is important for getting on the agenda and preventing a program from being cut. It is also necessary to ensure funding beyond a five-year timeframe.

A contrary point of view argued that although biological evidence can be a useful strategic argument for a particular program or set of policies, reducing arguments in favour of a policy to biological terms is not necessary. There are many ways to capture political interest and it is not evidence that drives health policy. Fear of working class revolution was the impetus behind universal social and health programs in Germany. Similarly, the women's movement has been strong enough at different points to get programs on the agenda. Champions, commitment and national identity, rather than evidence, are the key elements that have made health policy in the past. Thus, from this

point of view, it is a value driven rationale which emerges at a particular point in time that drives policy, not the nature or quality of evidence. This phenomenon is how we govern our societies and how policy changes over time. What is needed for many of the issues raised at the symposium is a new value base to drive policy.

Several participants argued for greater awareness of politics in the decision-making process. The political-ideological climate is important since evidence can also be ignored by politicians. Timing in the political cycle is important. Governments will act in an incremental way over several years, except for bold moves at critical points in their mandate. In this light, evidence is not enough. What issues become salient is a result of factors other than the presence of evidence. Another participant stated that the power of rhetoric should not be underestimated. Getting on the political agenda has to do with the challenge of capturing public consciousness. For this reason, rhetoric can lead to substantive change and may even be a pre-requisite to it.

Another view expressed was that the body of knowledge generated by the research community is not the same body of knowledge needed to make policy choices. These are two different worlds. Beneath the political trends that rise and fall with changes in government, there is a stability of themes. Policymakers need to look for windows of opportunity that arise as governments change office and public awareness rises. At these critical moments, "evidence comes in the side door." Adding policies is easy, implementing them is hard, particularly when it is necessary to affect income. This is obvious when the gap between departmental bureaucrats and treasurers is examined.

Sholom Glouberman argued that we are in the midst of a major transition between reliance on science as an authorititative form of knowledge and chaos or uncertainty. To start off the second day, he presented a matrix for comparing evidence, type of data and prediction and control for the individual, environment and interactive categories.

THREE PERSPECTIVES ON HEALTH	**Organism/ Individual**	**Social and Physical Environment**	**Interactive/ Relational**
Evidence	Hard scientific evidence is possible. Success or failure can be clear.	Medium: Possible to get hard measures of the state of the environment, more difficult to show	Weakest evidence. Multiple variables, at times impossible to attribute causality

		impacts of interventions.	
Type of data	Measures can be largely numerical	Numerical (and natural historical)	Cultural (ethnographic, narrative)
Prediction and Control	Less than physics	Less than economics	Least liable to prediction and control

Given the point we are at in this transition, scientific evidence works to convince some people but not everyone. This is an underlying source of tension for each block of health policy – public health, health care, health promotion and inequalities of health. It contributes to the logjam of ideas blocking a clear path to where governments should invest to improve the health of the population.

Part Four Recommendations

Recommendations for ways to move health policy forward emerged throughout the Symposium. One salient message can be drawn from each of the international health topics as well as from consideration of the TNP hypothesis.

> **International Public Health:** Canada's "two silos" of domestic and international health policy and research are an impediment to addressing new public health issues. Overcoming this separation is necessary.
> **Sustainable health care:**
> Debate around health care would benefit from recognition of health care in Canada as symbolic; an acknowledgement that public policy, like politics, is a game; and that public support for principles does not necessarily lead to support for actual policies.
> **Health promotion in developing countries:**
> International health efforts need to appreciate the complexity of social relations that affect health behaviour. Interaction appears promising for health promotion. To better address this block, health promotion ought to be considered an aspect of social policy rather than health policy.
> **Inequalities of health:** The case of Glasgow provides an example for other countries about how to move from research to public policy.

Other suggestions included:

- Include decision-makers, such as Members of Parliament, in discussions of policy
- Test ideas through concrete intiatives
- Re-consider the 1970s idea of a guaranteed annual income

- Learn from failures
- Take advantage of new funding for health research
- Mutual learning - Find ways to share experiences with policies aimed at interaction
- One strategy for advancing the TNP thesis is to underline *cost* to policy makers, underline the *threat* to the general public, and underline *governance* to the NGOs
- Other countries translate research into policy by establishing a doctrine whereby each ministry is told to do their part to achieve the end goal.
- In Glasgow, a "health impact assessment" (HIA) modelling approach is used to assess the impact of housing and other determinants on health. This involves target-setting of improvements.
- Make twenty-five, not five-year investments.
- Interaction/enabling should be a policy instrument

Recommendations for the *Towards a New Perspective on Health Policy* project focused primarily on the hypothesis. There was general support of the idea to aim policies at the interaction of individuals and their social context. To this end, it was recommended that the team concentrate more effort on what concrete measures would accomplish this end. Translating theory into programs was acknowledged to be the most difficult step in introducing new ideas. A long term pilot project may be the best and only route to truly test the hypothesis.

Conclusion

It was clear from the stimulating debate that emerged at the Symposium that the political and intellectual context is complex. In working on the hypothesis in relation to four international health topics, symposium participants were instrumental in bringing the *Towards a New Perspective on Health Policy* project one step closer to building a new view of health. At the end of the second day, President of CPRN, Judith Maxwell used the analogy of the blacksmith to describe this project. Producing quality products involves exposing the piece you are working on to the hammer of the blacksmith who will pound it and apply heat. The result is to forge a more refined and well shaped piece. In response to her comment that this project holds ambitious goals, a participant stated that it breaks new ground, the ideas presented here are not a speedy response to "crisis." They need time to be tested and proven.

Appendices

A. Articles Summarized as Background Material for the Symposium

Topic 1: ***International Public Health Issues***

Mayer, Jonathan D. "Geography, ecology and emerging infectious diseases" *Social Science & Medicine* (50) 2000:937-952,

Chen, Lincoln C., Tim G. Evans and Richard A. Cash "Health as a Global Public Good" *Global Public Goods: International Cooperation in the 21st Century* Inge Kaul, Isabelle Grunerg and Marc A. Stern (eds.) New York: UNPD, 1999.

Topic 2: ***Sustainable Health Care Systems***

Deber, Raisa and Bill Swan "Puzzling Issues in Health Care Financing" *Health Care Systems in Canada and Elsewhere*, National Forum on Health, Volume 4, 1998.

Topic 4: ***From Research into the Inequalities in Health to Public Policy***

Burns, Harry "Improving the public's health: The challenge of health inequalities" unpublished paper, 2000.

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