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Towards a New Perspective on Health Policy

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Executive Summary

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Executive Summary

Towards a New Perspective on Health Policy" provides a rare comprehensive overview of health and health policy. It is a response to a logjam in Canadian health policy, manifested by government inability to allay public concerns about the health care system, recurring crises in public health, uncertainty about the future of health promotion and little progress on implementing the consequences of recent findings about health inequalities. Fifteen separate short historical and conceptual studies and discussion papers were commissioned to flesh out the context of current health policy. Ideas and an intellectual framework were developed in an iterative way by presenting intermediate results to more than 3,500 people at over 90 different events. This final report is addressed to everyone involved in the health field, including government officials, health professionals, researchers and citizens with an interest in health and health policy.

The report takes a variety of approaches to the issues. It begins by examining the writing and publication of the Lalonde Report in 1974, perhaps the most prominent health policy document in recent Canadian history. It explores developments both prior to and following that Report, locating the current situation in a broad intellectual context. Historical and conceptual analyses find fresh perspectives on health policy, and lead to a number of ideas designed to unblock the current logjam and indicate possible directions for Canadian health policy in the 21st century.

The Lalonde Report introduced an important new idea about going beyond medical care to improve the health of Canadians. It led to the development and evolution of health promotion, at first encouraging people to take more responsibility for their own health, and later recognizing the contribution of healthy communities and environments to health. The policies advocated by the Lalonde Report seem to have had mixed outcomes. For example the Report's nutritional and exercise recommendations have largely been adopted, but there remains widespread disagreement about its overall impact on the health of Canadians. These debates suggested the need for a fuller exploration of other major stages of health policy.

A historical account of government health policy describes the beginnings of the public health movement, which gave us pure water, improved sewage and public sanitation. It moves on to the events leading to the establishment of universal health care in Canada, and the growth of health promotion after the Lalonde Report. It emerges that none of these major advances follow a neat and logical course. They all take a long time and progress towards eventual implementation occurs in fits and starts in a non-linear way. Unforeseen obstacles like wars and depressions slow things down. Ideological differences make continuous development difficult. Once adopted, there is dispute about their outcomes, so that the debate about whether it is health-related initiatives or general prosperity that is responsible for the increased longevity of Canadians is far from being resolved.

A subsequent stage of health policy seems to be emerging from research into inequalities in health which answers the question "Why are some Canadians healthy and others not?" This research has so far explained quite a lot about the nature and source of these inequalities, but it has not yet defined policy consequences of the research. There are strong ideological disagreements about what to do about inequalities in health and about the place of social determinants of health like social class and income. The report recognizes that debates of this kind have occurred at every stage of the development of health policy, going back to public health in the 19th century.

Aristotle's *Ethics* and *Politics* locate the concept of health in the broader field of living well, both morally and socially, and help us to understand some of the results of the research into inequalities in health. Aristotle's ideas explore the notion that the hierarchical nature of a society is reflected not only in gradients of social status but also in differences in levels of well-being and health. He identifies three kinds of resources for well-being: goods of the body, goods of the soul and external goods. This distinction recognizes the interactivity between the various goods and, later, the resources that are necessary for health and well-being.

An analysis of the literature on concepts of health shows that they can be categorized into three clusters: those that focus on the body as an organism, those that stress the environment, and finally those concepts that recognize the importance of the interaction between the two. This insight leads to the conclusion that *the quality of the interaction between an individual and his or her social context is a major contributor to health*. This provides a more dynamic picture of health and recognizes that positive interactions, such as those in good parenting, improve health, and negative ones, such as those in poor work environments, harm it. It becomes possible to conclude that health is a function of the dynamic interaction of many forces and has many characteristics of complex adaptive systems.

The report then traces theories of policy development from the hierarchical bureaucratic model, through a stage of policy planning, to more current views about policy development in complex systems. Frameworks for understanding policy development do not merely describe the process. They invariably indicate what a "well-functioning" process is like. And so they place a value on certain structures and behaviour. As our theories change, so do our views of what is good – the "appropriately-developed" policy of 1935 would be seen as dysfunctional today. The chapter concludes that policy development must today be seen as a non-linear process with many competing interactive complex forces. It therefore makes a distinction between three metaphors for policy: *levers,* appropriate to a mechanical view of policy; *investments,* which suggest a financial perspective; and *planting seeds,* which suggests a more biological or evolutionary approach.

The report concludes with an application of what it has learned to four case studies in public health, health services, health promotion, and inequalities in health. The public health case study looks at the contamination of the Walkerton water supply, which lends itself to accounts of how complex systems destabilize and adapt to unexpected changes. The next case study reviews the evolution of health organizations into complex networks of care and cure. It also enriches our understanding of the role of health care in the context of a broader health system, as part of the containing and redistributive function of social policy. The third case study examines the successes and failures of health promotion, and explains that these can be well understood in terms of the interaction between individuals and their social context. The last study of inequalities of health concludes that measures of health status are excellent indicators of the state of the social environment.

These case studies reinforce the conclusion that there are powerful interactions between the health and social well-being of individuals, between the different stages of health policy and between health and social policy. Some main recommendations follow from this:

- The first is to warn against the search for easy solutions based on static pictures of the health field, or on excessive simplifications of policy problems.

- The second urges that the most important role for health ministries is to ensure that the health edifice is in good repair, that is, that public health, the health care system and health promotion

are functioning well. A strong and viable health policy structure is a significant contributor to well-being and is largely redistributive.

- The third is that measures of the health status of a population are good indicators of its socioeconomic well-being, and, hence, are tied to the effectiveness of broad social policy.

- Finally, as we continue to improve our understanding of human development, we must increasingly pay attention to the interaction between an individual and his or her social context as a major contributor to health. Positive interactions improve health; negative interactions make people sick.

Bearing these in mind could provide new insights for all who share in the health enterprise – patient, surgeon, nurse, deputy minister, counsellor, hospital manager, citizen and taxpayer.

The next stage of our efforts is in the advance planning stage. One conclusion of the work is that these new ideas can only be applied in collaboration with policymakers and others who have a detailed understanding of particular local circumstances. We propose to work on such particular policy issues in three countries: Canada, the United States and the United Kingdom. There has been considerable interest among government officials, policy advisors, and researchers in the three countries to join us in this effort. We expect that the result will include some new kinds of policy solutions, which we hope will also allow us to develop very much more elaborate and detailed case studies that will be helpful in the three countries.