

The Health and the Changing World International Conference

Keynote: Health Policy in the Changing World

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Introduction

Health, wellness and health care are important to everyone. In most countries these are frequent topics in the media, not only because health affects us all on a day to day basis, but because it reflects personal income, global economics, access to transport, the environment and so forth.

If health is present in every dimension of life, it also implies that risk is everywhere. This has significant consequences for how we frame health policies and where we assign responsibilities for health in society.

(Kickbusch 2007)

For many, when we talk about health, this immediately conjures images of what health services are needed to improve our own, and our family's, health status. However, probably for those in this room, the term health also translates into a host of other policy directions and interventions that can improve the health of the wider community and prevent the onset of problems in the population.

“The links between health and the global policy agenda are well established” (Thieren 2007: 218). For instance, for some time we've witnessed an increasing focus on relationship building, collaboration and negotiation on health matters between countries. This is evidenced by global public health efforts to control communicable diseases such as avian flu, HIV/AIDS, SARS and poliomyelitis. This focus is also demonstrated through the development of shared policy goals such as the Millenium Development Goals for health, and legislative change for example, endorsement of International Health

Regulations (Thieren 2007). Especially in recent times, health has gained recognition as a foreign policy concern and political leaders are increasingly addressing health problems within their international relations agendas (Thieren 2007).

We all have challenges in developing health policy and systems that respond to the globalised world. And let's remember, the present global health crises are not primarily related to disease, but to governance (Kickbusch 2006). A major consequence of global restructuring is the weakening of public policy and interstate mechanisms (Kickbusch 2006).

Undoubtedly, the health of a society reflects its values and expectations. In turn, the health of a country's people has implications for their nation's wellbeing and prosperity.

Accepting the breadth of determinants of health, and that, in turn, health is clearly a shared responsibility, what does this mean? I propose many countries face the same challenges – struggling with disparate funding sources and fragmented services in health. It's certainly the case for Australia, New Zealand, the US, the UK and Canada, (Ashton 2005, Dwyer 2006, Canadian Institute of Health Research, UK Government).

What will it take to engage the relevant sectors outside of health? Is there potential for whole-of-government cross-sector success and would this include a health scorecard so that communities can see what education, sport and recreation, planning and infrastructure, local government, and agriculture and so on, are doing to improve health?

What would it take for more countries to have health policies comparable to Sweden and Finland that explicitly address equity and the underlying causes of ill health and the social determinants of health, *and* have outlined intersectoral action as a key strategy?

The findings of a 2008 World Health Organisation Commission flags that all participants involved in developing the resultant report were united in three concerns: a passion for

social justice, a respect for evidence, and a frustration that there appeared to be far too little action on the social determinants of health (CSDH 2008).

In view of that, this paper proposes there are three key directions that should be universally shared if we are to see world-wide improvements in health.

First, a new orientation for health policy around the world that is explicitly linked to increasing social capital and paving the way for good health on equal terms for the whole population. Inherent in this would need to be a radical shift to health policy debates being inclusive of an examination of the social values behind a country's decision making. This would include an analysis of cultural influences on ethics and morals because it is argued that otherwise, it is impossible to facilitate comprehensive reflection about health care reform.

Second, efforts to improve health have to be conducted at all levels of society, across government portfolios and in several social sectors. I believe that much of the system failure we see today is partly as a result of this shared responsibility not being adequately planned and coordinated. In many cases the responsibility for following up on goals and objectives and devising indicators rests on agencies outside health, for example, with local government. For instance – who's the main player responsible for preventing transport injuries or health promotion within communities?

Third, quality of life is, of course, inextricably linked with health and the quality of health care. Given point two, how will the quality and safety of a patient's journey be monitored and safeguarded across multiple providers and services and in respect to their expectations, as well as their experience? Monitoring change in health systems, and subsequently benchmarking, has to be from three perspectives; patients, clinicians and funders, and in terms of patient-assessed value, performance on clinical interventions and efficiency. The debate around health policy needs to address how current system reforms impact on quality of life and quality of care in the future. For instance, reduced length of stay in hospital is certainly a major cost cutting exercise that may free up funds for health

priorities other than hospital-based care. As well, reduced length of stay is a major contributor to reducing patient exposure to hospital errors and injuries. However, the impacts of reduced length of stay can have a number of unwanted effects and have the projected cost implications of these been done for the longer term? For example, the intensity of patient need on staff during their hospitalised period can result in significant workforce issues, such as role dissatisfaction and high attrition rates. More complicated home-care needs which impact on both patients and carers also need to be taken into the equation – will the community-based workforce be available to manage people in their homes?

Priority setting, responsibility, accountabilities and leadership

Is the responsibility for health then in the right hands? For many nations in order to improve their population's health, the aim is to achieve intersectoral action for health which results from policy reforms that:

- Link health and welfare sectors;
- Consolidate the importance of healthy and health-promoting environments, at both strategy and individual action levels;
- Achieve greater equity so everyone shares the benefits of health system improvements;
- Engage with their communities and ensure people know if they are getting the best outcomes from their nation's investment in health; and
- Get the balance between prevention and treatment right.

However, perhaps the most critical aim of any health policy development should be to explore the moral and ethical basis for decision making. This will pose a number of challenges. Making a reform in one area will undoubtedly produce a response in another, and those cause and effect relationships have not always been well explored. For example, the length of stay issue previously discussed is one such example. Similarly, moves around the world to prevent young people having easy access to alcohol, can in turn, see the emergence of new, more easily accessible and perhaps more harmful drugs.

The point being, these are very complex concepts to be deliberating; this is the ‘stuff’ of who pays for what, who will be the winners and losers, who will make the hard decisions and how will we manage that. As well, universally we still haven’t worked out how consumers get to be meaningfully involved in policy debates. Sometimes consumers and carers seem to be tacked on as just another part of the health system that needs to be sorted out, along with the medical workforce, hospitals, pharmaceuticals and so forth, instead of being the *raison d’être* for its existence. If we want to make any headway on the three key directions I raised at the start of this paper, and aim to have health systems structured around the person not the provider or the infrastructure, then how will the role of consumers feature in not only decision making, but also monitoring and evaluating progress? In the health policy context, this would entail involving community members in developing and implementing the policies, in decisions about the delivery of health services and the allocation of health budgets, and broader systemic questions about the type of health system they want to have (Gregory, J, Hartz-Karp, J & Watson, R 2008).

The rhetoric of community engagement has been present in government language in a few jurisdictions for some time, but it’s not in the sense that many would consider meaningful engagement. If we consider community engagement to mean more than community participation, community consultation, community development and public relations (AUCEA 2005a, p. 3), and we adopt a definition of reciprocity, that is a two-way relationship and one that is mutually-beneficial and knowledge-driven (Garlick & Langworthy 2004), then it’s not what governments do in the main. For example, often there may be explicit commitments to engaging with the community about health issues and health services, as evidenced through Departmental strategic plans, but in my mind this constitutes consultation not engagement. As well, in many health policy sectors, these processes tend to be inconsistently practiced, at times at minimal levels both in terms of participant numbers and geographical reach, and with short consultation processes built around community submissions (Gregory 2007, 2008). While consultation processes provide some opportunity for the community to contribute to the policy process, the community's input is limited, with no opportunity for two-way discussion, learning, and dialogue. Community engagement needs to go beyond

traditional consultation if meaningful community input is to be achieved (Jones, Baggott & Allsop 2004; McBride & Korczak 2007). There is increasing evidence that the community can contribute in a meaningful way to policy decisions, but more and more, it is being recognised that this requires an interactive and deliberative approach (Gregory, Hartz-Karp & Watson 2008).

So, while most countries have tried various methods of consumer and carer engagement, whether it is via citizens' juries or consultative structures, achieving informed, meaningful and sustainable engagement remains relatively haphazard.

However, there are some pockets where there are examples of community participation that is heading in the right direction; that is, communities addressing issues and determining the resources and control over decision making processes, often beyond the reach of people normally excluded at the local and community level. For example the Healthy Cities movement is a local governance model that can be adapted worldwide to promote health equity. A good example of this is here in Thailand where we see a participatory urban governance model, recognising the importance of community participation in addressing urban living conditions and the impact on health. Nine communities along the Bangbua canal in north Bangkok initiated a slum upgrade project in the wake of a threatened eviction due to a proposed highway construction project. As a result of public hearings and the community working with government agencies, non government organisations, and local universities, loans were provided for housing design and construction, 30 year leases were gained by the participating communities, and housing units have now been built. The Bangbua experience has taught the world that community participation through community networks is effective in building community capacity and promoting health (CSDH 2008).

In Australia, deliberative approaches to community engagement that involve the community in discussion and deliberation about issues and ideally lead to concrete proposals that can be adopted by policy makers are now being considered for health (Gregory, Hartz-Karp & Watson 2008).

The definition used by the Deliberative Democracy Consortium (2008) is useful:

'Deliberation is an approach to decision-making in which citizens consider relevant facts from multiple points of view, converse with one another to think critically about options before them and enlarge their perspectives, opinions, and understandings.'

In 2008, we are also hearing more and more about self care – does this self care management trend mean that the way consumers will be engaged in decision making is to manage their own care using the Internet, keep their own health record, and being increasingly responsible for obtaining the services they need? This is concerning because such a move may not necessarily be about empowerment but could be more about shifting responsibility and even ultimately blame, if something goes wrong. We all know there are serious health workforce issues now and further predictions of demand far outweighing supply by 2016. I personally hope that the pendulum for consumer involvement doesn't swing to the point that the solution is having people assume the central, unpaid and even untrained, role in making decisions about their own and their families health *because* we didn't collectively draw the line and think about these hard issues now.

So how do we decide the areas to concentrate on more than others and who should have that role? Will the data we now have in terms of burden of disease for instance be enough to decide to prioritise mental health over child health? How do we prioritise our approaches, for example, primary, secondary or tertiary prevention or services, and the distribution of funds between them? Are the existing mechanisms in place adequate for this kind of decision making and how does this wash up in a democracy and across province, state, and federal jurisdictions? Is it even possible to have one health system that is community-driven with single governance, management and funding?

Determining how much is spent on health now and how much it will cost in the future is a critical 'hot topic' then for public, private and not for profit sectors, all levels of government, and departments within governments. And, perhaps this is topical at this time more than ever, because of global economics. If funds are limited in the future, how

will we close the gaps and do something, if not more, to counteract those who don't even know they're at risk? I'd suggest that the present is an opportune time to also look at what's the cost of unhappiness in the long term? There is evidence that the main sources of well-being in advanced economies are a result of connectedness – with family and friends. Yet, in hard financial times, with folk needing to work more, and even work away from their home, that personal and social connectedness is likely to be at risk.

In this context of a rapidly changing world with many unknowns, how could/should we choose our health leadership? Is there a better way? How can we be more effective, evidence based, visionary? Given the pressures of population growth, an ageing and increasingly chronically-diseased patient base, and emergency department usage for non-urgent care having been identified as an issue worldwide (Hansagi et al. 2001; Oktay et al. 2003; Ruger et al. 2004; Ting 2005), who determines the relationship between choice, values, the optimal health system and funding and expenditure? At present, government health departments tend to take responsibility for the funding of health, but not necessarily the responsibility for errors, near misses and adverse events. Currently, while the figure head for health, in some countries anyway, would be a politician, there are various groups which may also lay claim to having, or be considered by many to have, the leadership role for health. How do we make those responsible for final policy decisions and thus leadership in health, and policy implementation, accountable to the broader population?

Examining the fundamental values underlying health policies

Let's start with how this occurs currently. Under the Westminster model, adopted throughout the Commonwealth, there is a clearly defined policy development process. This process incorporates a degree of consultation with a range of stakeholders in the formulation of a policy statement, development of a set of strategies for implementation of the policy, and formal endorsement by the appropriate level of government, commonly Cabinet. Another contemporary model used for policy development, the sequential policy development cycle, in essence shares the same stages – agenda setting, policy research, development or adoption of an ideological framework, the formulation of a

discussion paper (green paper) and mandatory public consultation, the consequent development of policy (white paper), lodgement and adoption by government, and a program structure with monitoring and evaluation strategies.

So while many would agree that policies result from the identification of emerging issues or problems by decision makers, legislation, interest/lobby groups or the community, and we generally have consumer consultation, there probably isn't consensus that we always have meaningful community engagement. If we did have authentic engagement in decision making, one would expect to see something beyond the acquisition of knowledge among participants, and more of a shared values approach. That is, the objective would not be about doing *to* consumers, for example educating and training them so they can make decisions in the way that those decisions have always traditionally been made. But more about a shift that enables the fundamental values underlying health policies being grounded in the specific values of the consumers and communities affected by the policy. Thus the values that have meaning to the community members that a health system serves would be ingrained in the respective health policy and would be reflected in the institutional and policy leadership, and the organisational culture of the bureaucracies. If the objective is to conduct root and branch reforms, that is, major overhauls of systems so they are in fact people centred, then key to achieving this will be getting community members to subscribe to the values of the policy leadership and leading institution. This capturing of 'hearts and minds' will be more likely to result in sustainable systems because it will be easier for people to adopt the policy because the values underpinning it are already part of their ongoing life and the environment in which they live. For instance, there would be little point in a new health policy to shift a system from treatment to prevention if the community drive isn't there. It's important to recognise, of course, that the presence or absence of such community drive is going to be linked to the support and information available to people in respect to their decision making and ultimately, their health choices. That's the premise behind the making healthy choices easier movement; sustainable changes need to be based on choice not direction (Department of Health 2004). Governments can't claim or pretend to 'make'

the population healthy but they can support people in making better choices for their health and the health of their families (Department of Health 2004).

In reality, policy makers often reason by metaphors to boil down a set of complex policy tradeoffs into a few consistent strategies and principles, such as global health as an investment to maximise economic development or global health as public health seeking to decrease the worldwide burden of disease (Stuckler & McKee 2008). However, strategic health policy discussion papers (green papers) and the subsequent policies (white papers), in my experience as a previous policy advisor, are generally framed around an ideology. So, the principles of social justice or the goals of primary health care might constitute such a conceptual framework. I've also had experience in policy developed centred around economic rationalism and the creation of internal markets and managed competition, and in health systems built on the concept of the split in responsibilities between funders, purchasers and providers.

In the United States and Canada, the social contract theories tend to provide the ideological framework for health policy. Although, each nation translates that agenda differently; Canada's emphasis tends to be on humanitarian good which stands in stark contrast to the narrower conception of self-interest that underpins health policy in the US. Jecker and Meslin (1994) have been working on the concept of comparing and contrasting the basic ethical values underpinning health care policies, particularly using the US and Canada as a study, for over a decade now. They've found the ethical traditions in a country will support strikingly different approaches to health care.

The “... laying bare and questioning the fundamental values underpinning health care systems” is increasingly gaining support (Jecker & Meslin 1994: 196) as it is argued that how can a major overhaul of a system occur, unless there is a moral and ethical debate, rather than only a political or economic one. In a number of circles, it seems that ideological frameworks for health policy that are likely to gain traction will be those that are characterised by a humanitarian (altruistic) focus and people-centred identity.

The Future

In conclusion, I'd like to propose that there's a simple framework characterised by three defining moves that would have cross-national relevance for a process for future health policy development.

1. Look inward to the communities for which the health system exists

This would entail policy makers drawing on the narrative data that exists within their communities, or constituencies. You could refer this to a participatory policy change process – the premise being that health policy should be informed by a careful evaluation of the social values held by different groups in the community (Richardson 2005, 3) not simply the traditional and mandated consumer consultation that usually occurs around green papers. This will also mean taking a deliberative approach to community engagement so that consumers understand and can work through the trade-offs that are so integral to health policy development. To achieve this end, we would have to create the circumstances where ordinary citizens are willing to tackle difficult and often value-laden problems; giving them access to information from **all** perspectives; and affording them adequate time required to question, reflect, and have dialogue, preferably with those who think differently to them (Gregory, J, Hartz-Karp, J & Watson, R 2008).

2. Connect engagement to morals and ethical basis for policy

Here I want to stress the need for a new direction; being the recognition of the role of social values in health system reform. It's not about aiming for a single 'best' health system, but more about designing various options that are more or less consistent with different social goals (Richardson 2005, 2). This will require the translation of the findings from this first step, and then subsequent bridging a number of domains so the findings are integrated. This is critical because of the trans-disciplinary nature of health and the need for intercultural engagement in respect to recognising and incorporating moral and ethical values. In alignment with the first move, this step will also require a significant broadening of the conversational and policy debates as previously outlined.

3. Look outward to broader trends and movements for change on a global scale

This move is about taking into account important external imperatives, such as the quality and safety agenda and accountability frameworks. So, this suggested approach is not about working in isolation of other system reforms, but more about couching health policy development that is based on ethical and moral values within the broader policy context, not the other way around. This wrong sequence of priorities that we've witnessed in the past might explain why we see so many proposed changes to the financing and delivery of health services, and a focus on issues of relatively minor significance, while failing to adequately address the major inequities and system deficiencies (Richardson 2005, 1). And, as a matter of principle, we need to adopt a new global approach to governance. At the start of this decade, the United Nations Development Program issued the need for such new directions and a move to multi-player and global accountability; a focus on economic, social and cultural rights; and a shift from punitive (name and shame culture) to a positive ethos (UNDP 2000).

Conclusion

This paper has described and discussed just some of the issues that currently face most, if not all, health systems. Many of the issues are not new, but the ongoing debates with recurrent features in "various waves of health sector reform" clearly demonstrate all is not as well as it could be (Ashton 2005). The confusing division of responsibilities, uncontrolled costs, inadequate prevention strategies to spare people from avoidable suffering and death, insufficient public health system infrastructure, and critical health workforce shortages remain unsolved issues in 2008.

Attaining the model health policy and a resultant ideal health system is no easy challenge. There is a serious lesson in the old Irish joke that "if you want to go there, I wouldn't start from here". The model a country chooses will have to fit with their history, their culture and take into account their institutional arrangements, even as it sets something of an exemplar we all might aspire to (Podger 2006).

In this session, I've discussed three key directions that should be universally shared if we are to see world-wide improvements in health. As well, a simple framework characterised by three defining moves that would have cross-national relevance for a process for future health policy development has been proposed. While much progress has been made in the past century, many challenges remain. As well, we have enough shared history now of what does and doesn't work, to be confident now that no matter how health policy is disguised in political terms, that unless it is grounded in the fundamental belief systems of the people it is to serve, it will simply either translate into wishful statements or lead to inequalities (Thieren 2007). Being early in to a new century is an opportune time to strategically and explicitly build stronger health systems through ideologically, morally and ethically sound health policy, worldwide.

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