Politics as a resource for health

Michelle Hughes | Jul 26, 2014 1:09PM

Evelyne de Leeuw, Associate Professor, Public Health and Health Policy at La Trobe University writes:

Globally, non-communicable diseases (NCDs) constitute the main causes of morbidity, mortality and disability. This has been recognised by the United Nations as a major international crisis. The international community has started to coordinate its efforts to deal with the crisis. This is a complex affair with wide-ranging consequences spanning communities, local governments, NGOs, industry and global agencies. They all recognise the 'wicked' nature of the problem as driven by social, commercial and political determinants of health.

A solution, they agreed at a conference in Helsinki in 2013, would be to develop Health in All Policies (HiAP).

At local levels Australia has taken up this challenge. In South Australia, for instance, a coordination unit has been set up to develop HiAP. The 'Healthy Together Victoria' initiative aims to address the complex policy interactions and community development issues that make health.

However, recent budget proposals suggest that Australia as a nation is withdrawing from a systemic, comprehensive and visionary health policy development approach for which the country was world renowned toward the end of the 20th century.

The World Health Organization is committed to the further development of insights into how HiAP can be created. As a spin-off of this work nine questions to inform the development of HiAP were developed. Australian advocates may consider these as useful political science pointers for their actions.

Health is not created by doctors, nurses or pharmaceuticals. Health is created by people and the societies they shape and are shaped by.

This dead horse has been flogged ad infinitum, and not just by the public health community. Doctors, nurses and pharmaceutical industries equally commit to this gospel so compellingly professed by the likes of Hippocrates, Rudolph Virchow and the World Health Organization.

The 'Holy Books' of the health world reiterate and regurgitate the social attributes of health and well-being time and again. Nearly a century ago (in 1920) Charles-Edward Winslow wrote about the broad social engagement required for what he then called 'The New Public Health', in the process defining public health authoritatively. Distracted (or blinded) by the triumphs of the applications of the 'germ theory' the comprehensive social approach only re-emerged in the 1970s, through the Health Field Concept advocated by scholars Blum and Laframboise, and in politics in the Canadian Lalonde Report (1974).

The idea of 'intersectoral action' (ISA) gained some traction through the Declaration of Alma Ata on Primary Health Care (1978). The 'consensus' became that health care, through action with other sectors like housing, education, or engineering, could create better conditions for population health. Of course the 'consensus' was quickly corrupted, putting disease at the centre of the argument, rather than health – leading to turf wars and impenetrable sectoral silos.

'Let's not look at action. Let's look at policy', US nurse scholar and community activist Nancy Milio considered. She found that virtually every organised element of public life, institutionalised through policy or governance, impacted on people's health opportunities. This view was integrated in the Ottawa Charter for Health Promotion (1986), calling for the development of Healthy Public Policy.

The new clothes of the Healthy Public Policy emperor are called Health in All Policies (HiAP). South Australia and Finland are the parents of this prodigal health policy child. HiAP was the subject of a high-level global WHO conference in Helsinki in June, 2013, and a recent resolution in the World Health Assembly.

Unfortunately policy-making has never been a strong suit of the health promotion community. Driven by behaviourist tendencies, many health promoters attempt to apply social psychological models to political problems. They often deny or reject the vast body of knowledge accumulated in the political sciences that would explain systems rather than individual driven power exchanges.

More than Healthy Public Policy ever has, HiAP seems to generate some real traction – it connects well to global discourses around the social determinants of health, health equity, and Universal Health Coverage, although this full potential is still to be attained in Australia. Elsewhere, inventories and manuals are published under the HiAP aegis. In the United States, a comprehensive guide for local governments was published. The Rockefeller Foundation and WHO supported the development of HiAP analyses in the African, South-East Asian, and Western Pacific regions.

A persistent issue in many publications on HiAP is that in discussing development and implementation of such policies there is confusion with intersectoral action. HiAP is often used interchangeably with ISA, although analytically action does not necessarily equal policy. Action, we thought, is a policy tool or instrument. Action can lead to policy, e.g., through advocacy, activism or entrepreneurship. But policy is not action is not policy.

To demonstrate this perspective and argue for the importance of a public policy and political science gaze we formulated nine questions grounded in *"processes of conflict, cooperation and negotiation in taking decisions about how resources are to be owned, used, produced and distributed."* :

- How has the problem been framed and by whom?
- Within the problem definition and tentative policy logic, which policies are already in force or in development? Are there any measures of success?
- What information is there about the problem, its magnitude and consequences, and relevant stakeholder positions, now and in the future?
- What facts, ideas and assumptions constitute the policy logic in relation to the problem?
- What evidence, experience and opportunity exist to develop winning alternative approaches?
- What social, economic and institutional 'win-wins' can be established? What gains can be identified?
- What are the power, priority and support positions of all stakeholders in particular policy proposal?
- What politics are involved in the initiation and final stages of policy development and adoption?
- Have policy implementation barriers and facilitators been considered and integrated in policy formulation?

Each of these questions is grounded in the political science literature and perspectives on the core tenet of policy-making: who gets what, why and how? Although this involves a comprehensive primer of political thought, our call to the public health community is that (a) health is political; (b) a political view of health is constructed through the cunning framing and massage of opportunity, and (c) health is a potential resource to all, not just the prerogative of a group of –albeit powerful – professions and institutions.