Health sector reform has been high on the international agenda for more than a decade, driven by rising costs, globalization and a political resurgence of interest in market solutions to what were previously seen as the responsibility of the welfare state. For many it is hard to remember that less than 20 years ago, ideas now taken as part of conventional wisdom were to some extent unimaginable. The first of the three books reviewed here, Drache and Sullivan’s *Health Reform: Public Success, Private Failure* provides a useful reminder of the relationship of current health care reform discourse to its wider political origins.

*Health Reform: Public Success, Private Failure* began as a seminar on reforming Canada’s health care system, held in 1996. The book contains papers presented at that meeting, and many commissioned expressly for publication. Contributors include leading international commentators on health and social policy, e.g. Yale University’s Ted Marmor, Columbia’s Mary Ruggie and Canadian economist, Robert Evans. Throughout, the major theme is that of the tensions between publicly funded health care and the increasing enthusiasm of decision-makers for health systems driven by market dynamics. While consideration of the Canadian system forms the core of the content, papers from US and Australian authors, and the way the topics are approached, ensure that the book has an international perspective and relevance.

The 18 chapters are organized into five parts. Their titles give something of a sense of the flavour and organization of the book. They are as follows.

1. Public–private conflicts in health policy.
2. Restructuring Anglo-Saxon health systems: shifting state/market boundaries.
3. Decentralization and devolution: new state forms and practices.
4. The political economy of health care reform in Canada.
5. On the frontier of reform.

In their introductory chapter, Drache and Sullivan identify three major objectives for health reform, which provide the conceptual organizing framework for much of the book’s content. The first, and they argue, most important consideration, is ‘how to sustain a public commitment to a comprehensive range of health services for all citizens’. The second is how to improve the efficiency of health care services in times of fiscal constraint.

The focus on these objectives, particularly the first, reflects the fact that this publication is clearly...
more sympathetic to a Beverage-style model of publicly financed health service provision than much of the literature on health care reform. In fact, the views of many of the contributors appear well encapsulated in a comment (attributed to Robert Evans in Ted Marmor’s chapter), which refers to the influence of market-oriented US ideas on health system reform as ‘intellectual acid rain’, which falls on their Canadian neighbour.

Many in the health promotion field may see the book’s title and think that this is a publication purely concerned with health ‘care’, and hence perhaps focused too ‘downstream’ to be of great interest. If so, they would be mistaken on two counts.

Firstly, the third objective proposed by the editors indicates why this is one of the more relevant publications on health reform for a health promotion audience. According to Drache and Sullivan, the third objective of health reform should be how to ‘devise social arrangements which engender healthy populations’. This perspective is canvassed most fully in the book’s final chapters, which deal with the social determinants of health.

For example, in their chapter ‘Governing Health’, Lavis and Sullivan examine the important contribution of working life and labour market arrangements to health as well as considering the type of governmental structures required to take a broader, more holistic view of health determinants. The book’s final chapter, titled ‘Health, Health Care and Social Cohesion’ by Canadian J. Fraser Mustard, sets out a persuasive argument for social investment in the early years of life, and for the significance of trust and social capital as the basis for a healthy society.

There is a second reason why this book should be of more than passing interest for readers of Health Promotion International. This is that the book’s contributors make a persuasive case that how a health care system is organized and funded can itself be health promoting, in ways perhaps not widely recognized.

This capacity of a publicly funded health system to foster a sense of a caring society, in which people see themselves as citizens rather than consumers, is a theme running throughout the book. As the editors comment in their introduction ‘markets may be back with a vengeance but health care remains a stabilizing instrument of citizenship at a time of global instability’.

Publicly financed health care systems which provide universal coverage and access to care do appear to offer equity benefits and better health outcomes than alternative models. However, even in these circumstances there remain non-financial barriers to health care usage, and disparities still exist, e.g. in uptake of preventive care by lower income groups. Nevertheless, there appear to be broader, if diffuse, benefits to health from a publicly financed system. As Mustard states:

A society that decides to make health care available to all of its citizens through a universal insurance system, makes provision of health care a potential institutional structure to help sustain social cohesion and trust (p. 334).

While much of the book therefore is concerned with social and health care arrangements that are ‘health promoting’ in the broadest sense, health promotion tends to be treated as a strategy targeted at individual lifestyle. For example, Gail Donner’s challenging chapter on the ‘fallacy of demand reduction’, i.e. demand reduction as increasingly embraced as part of managed care in the US, equates health promotion with health education efforts to, e.g. stop people smoking. Donner argues that demand reduction strategies in isolation from broader system reforms and ‘upstream’ public policy change, can themselves become both victim blaming and ineffective.

In their chapter, ‘The Virus of Consumerism’, Feldberg and Vipond argue that health promotion itself represents one of the instances in which market-oriented health care systems treat people as ‘consumers’ rather than citizens.

The answer to why health promotion is viewed in this way, in a book explicitly concerned with the social determinants of health, may perhaps in part be explained by the relationship of several contributors to the Canadian Institute for Advanced Research (CIAR), an organization closely associated with the development of the ‘population health’ perspective on health improvement in Canada. For example, Fraser Mustard was the founder of CIAR, and another contributor, economist Robert Evans, is a CIAR fellow. Perhaps not surprisingly then, to the extent that Health Reform deals with the health care system’s role in the broad domain of prevention, the perspective is strongly ‘population health’ rather than ‘health promotion’. While this may concern some

Health Promotion International readers, they should not let this detract from the fact that this is an important, informative and refreshingly critical (in the best sense of that word) book. As well as providing fresh insights on the social determinants of health, the breadth and quality of Drache and Sullivan’s text will be helpful to all those with an interest in health improvement to better understand the broader policy context in which health sector decisions are being made.

In contrast to the ‘whole of system’ policy perspective of Health Reform: Public Success, Private Failure, the focus of John Davies and Gordon Macdonald’s book is on the more specific elements of health promotion research and practice. The contributors are drawn from the UK, Australia, the USA, Canada and a number of European countries, and most are well known in international health promotion circles.

As with the Canadian book, Quality, Evidence and Effectiveness in Health Promotion has its origins in a conference, in this case the Third European Conference on Effectiveness: Quality Assessment in Health Promotion and Health Education, held in Turin in 1996. However, while many of the contributors participated in that event, the book’s 11 chapters were developed after the conference, and many include references as recent as 1998.

The book is divided into three parts, broadly reflecting the themes in the title.

Part 1, ‘Methods for Assessing Evidence and Effectiveness’, contains three chapters, one an overview of health promotion in the United States, and two which are concerned with measuring effectiveness and evaluating health promotion in various community settings. Part 2, ‘Methods for Assessing Quality’ consists of three chapters which each provide practical guidance on different aspects of quality assurance and assessment in health promotion. The four chapters of Part 3, ‘Approaches to Synergism’ are more of a mixed bag, with the first two chapters providing case studies intended to illustrate the synergy of linking effectiveness measures with quality assurance. Of the final two chapters, one provides an international overview from the perspective of a World Health Organization working group on quality assurance and effectiveness, and one, by the book’s editors, provides a summary of the ‘state of the art’, and suggests a number of steps and principles for improving effectiveness and quality assessment in health promotion.

The real strength of this book is the range of practical models, tools and techniques presented. For example, the chapter by Baum contains a useful tool for monitoring the changing expectations of key players in a community-based health promotion initiative. An approach of this type, as Baum notes, could potentially be of great value in helping make explicit changing and conflicting objectives, and in analysing progress of an initiative. What results is the construction of a ‘stakeholder-focused’ approach to outcome assessment, which recognizes that interventions in human systems are likely to have multiple impacts, and that assessments of the value of these effects are likely to differ according to where one stands.

Similarly, Speller and colleagues provide useful guidance in tracking and evaluating the progress of alliances for health; Springett provides a framework for indicator development to track the effects of policy change on health and social well-being in a healthy cities initiative (and highlights the difficulties involved); Haglund and colleagues present a quality assurance instrument based on the SESAME health promotion planning model. The book contains many more examples than this brief selection can do justice to.

While issues of effectiveness and quality assurance are well covered, the book is less helpful on the question of evidence in health promotion. Accepting that this is intended as a publication to improve and inform practice, nevertheless one might have expected from the title a more organized and comprehensive discussion of the challenges associated with ‘evidence-based’ health promotion, e.g. those associated with theories of knowledge, power and the nature of social systems. Some of these issues have been raised in recent issues of Health Promotion International.

Another issue which the authors might have considered for inclusion, and one which often figures strongly in discussions of quality assurance elsewhere, is the role of management and leadership.

This topic is well covered in David Hunter’s short publication Managing for Health, prepared for the London-based Institute for Public Policy Research. Hunter is Professor of Health Policy and Management at the Nuffield Institute. This report is primarily concerned with the contribution of management to achievement of the Labour Government’s objectives for Britain’s National Health Service (NHS), and its main theme is the importance of effective management in moving from a focus on health care to a focus on health.
Hunter argues that a new type of management is needed to move beyond the market-oriented approach of the so-called ‘new public management’ which has dominated the health system since the early 1980s. This does not mean, however, a return to the inflexible bureaucratic models of the past, but needs to consider a management approach consistent with the ‘third way’ in British politics championed by intellectuals, such as Anthony Giddens. Hunter suggests a way of thinking about ‘managing for health’, where the goal of management is health gain and health outcomes, rather than the management of inputs for health care.

Hunter identifies a number of key health policy themes that managers will need to deliver on in the policy context created by the government’s NHS reforms. These include:

- a commitment to narrowing the health gap;
- a commitment to quality;
- a greater emphasis on primary health care.

The first theme Hunter suggests will require nothing less than a paradigm shift in the way health services are managed, requiring managers to develop a ‘whole systems’ way of thinking and to actively promote ‘joined up solutions to joined up problems’. For Hunter, good management is critical to closing the gap between policy and effective implementation, and this is particularly true in terms of addressing health inequalities.

Hunter identifies a number of key skills health managers will need to develop. These include the following:

- Building alliances and networks with non-health organizations, and the capacity to work within alliances.
- Talking and listening to users of services.
- Developing information and intelligence databases to support the new public health.
- Having a strategic framework based on health improvement.
- Paying attention to the organizational forms needed to fulfil these functions; including development of vision, culture, people and skills.

While Hunter’s report is very much focused on the UK, the principles it espouses have international relevance, and its public health perspective makes it highly relevant to a health promotion audience.

It is useful to see these three publications as a ‘package’. Together they provide a policy overview of health care reform; some specific guidance, on how, within that context, health promotion can move to more effective practice; and a consideration of the role of management as the key linkage between policy and practice.

A comment contained in the editors’ introduction to *Quality, Evidence and Effectiveness in Health Promotion* provides an example of the lessons for health promotion in the health care reform literature. Davies and Macdonald note that a key theme at the conference which inspired their book was that the development of an evidence-based approach to health promotion would help ensure that health promotion remains ‘at the forefront of local, national and international health policy development and investment ...’ However, a reading of Drache and Sullivan’s book perhaps provides a more realistic perspective on where health promotion sits in the eyes of both policy commentators and health system decision-makers.

While health promotion as yet is not at the top of the health reform policy agenda, the insights contained in these three publications help point the way to how health promotion might achieve this position in the future.

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In 1998, the British Medical Journal commemorated the 150th anniversary of the first Great Public Health Act. Christopher Hamlin was among the authors who reflected upon the achievements and contemporary relevance of the legacy of Edwin Chadwick and his contemporaries. In this lively and readable book, Hamlin develops the idea that public health in Britain in the first half of the 19th century involved two transforming questions. Firstly, how broad public health was to be and how the ‘moral economy of medicine was to mesh with the political economy of industrial capitalism?’ The second is how Chadwick, in the name of efficiency and science, was able to equate in the public mind sanitation and sanitary works with the attainment of political stability and social justice.

Chadwick was the central actor in the sanitary movement in the turbulent 1840s. His Report on the Sanitary Condition of the Labouring Population of Great Britain, published in 1842, argued that the primary cause of pauperism and misery was not poverty or rampant capitalism, but filth. To Chadwick, the water queue, the dung heap and the cesspool were the causes of moral decline, fever and death. His arguments were a counterpoint to the more radical visions of William Cobbett and the Chartists. Frederich Engels published The Condition of the Working Class in England in 1844 and the Communist Manifesto in 1848. Work, wages and food were rejected as remedies for pauperism in favor of watering and sewering. The notion that poverty itself was the cause of illness was, for Chadwick, unthinkable. He resented the inclusion by William Farr of the category ‘starvation’ in the bills of mortality, arguing that it was impossible for a person to starve to death in London. To admit this would be to admit to a failure—not just of his sanitary agenda, but of his whole program of utilitarian reform.

As a young barrister, Chadwick became the private secretary to Jeremy Bentham, the utilitarian philosopher. After Bentham’s death he became a civil servant and architect of some of the most far-reaching legislative reform in the early Victorian period. He drafted the revisions of the Poor Laws and was subsequently the administrator for the Poor Law Commissioners. The Benthamite prescription for pauperism was deterrence. The pain of the workhouse was to be greater than the pain of poverty and poor relief. Chadwick became ‘the most hated man in England’. It was the miserable failure of the workhouse system which lead Chadwick to public health. In his report, he made a case that England was ‘hideously and dangerously insanitary’. A committed miasmatist, Chadwick attributed the cause of fever to overcrowding, reeking privies and humid marsh air. This view did not go unchallenged, and not just from contagionists. Thomas Wakley, the editor of The Lancet charged that the new poor law itself was the cause of fever. William Pulteney Alison was the most vocal medical opponent of sanitary monotheism. He rejected the prevailing view that poverty implied sin and was in favor of the retention of poor relief, knowing from his practice the corrosive effects of poverty on human health, character and conduct.

Chadwick’s biographers have painted him as a fearless and centralizing bureaucrat, England’s ‘Prussian’ Minister who was ultimately defeated by rich and powerful interests. To some he was the avenging angel of sanitation who rooted out corruption in local authorities and the funeral industry, and forged powerful coalitions between the bureaucracy and evangelical Christians determined to save the souls of the industrial proletariat. To others he was a stern class warrior and an uncompromising monomaniac. Upon his demise The Times trumpeted ‘We would rather take our chances with cholera than be bullied into health by the likes of Mr Chadwick’.

Hamlin, whilst remaining in awe of Victorian sanitary achievement argues strongly that it was achieved at a cost and warns against receiving too warmly the history of the victors. Then, as now, there were choices to be made and political struggles to be fought. Chadwick’s ‘technical fix’ to the problems of poverty and inequality prevailed. It prevailed because he was able to manufacture the requisite authority by appeal to flawed, miasmatic science. It prevailed because
he was able to pioneer a new role for government in improving health—to investigate and define real problems, to recruit problem-solving science, to develop pragmatic regulation, to evaluate effectiveness and to place these activities at the centre of State responsibility. And it prevailed because of the ineffectiveness of some groups, most notably the medical profession, to clearly articulate their understanding of the relationship between poverty and ill health.

As governments and experts grapple with the implications for human health of urbanization and population growth, the revolution in communications, the globalization of industry and government, ecological sustainability and climatic change, the ghost of Edwin Chadwick looms large. Can there ever again be value in an ideologically driven crash through approach to the paralysis induced by complex problems? Is science better able to contribute to debate and decision-making than it was in the time of Chadwick? What will it take to put public health at the centre of the agenda of government, as the environment movement has so successfully done over the last two decades?

Public health is not ‘an obscure offshoot of medicine or a marginal division of civil engineering’, but a ‘vast and unexamined part of our culture’. Beneath the veneer and language of science and medicine hide our most primitive notions of what health is and what it should be, and under what circumstances governments can or should act to defend it. Christopher Hamlin’s re-examination of the life and revolutionary times of Edwin Chadwick, public health icon and inventor of civic hygiene, illustrates how the struggle for public health occurs alongside and is inseparable from other social and political aspirations. It deserves a wide readership.

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