Academy of Social Sciences Seminar, Monday 4 December 2017: Historical and International Perspectives on Health

Christopher Sirrs

Introduction

The American author William Faulkner once wrote, 'The past is never dead, it is not even past.' Historians recognise that events in the past are rarely final, but continue to animate and shape the present. Unfortunately, this insight is not shared by many policymakers who, under immediate administrative and political pressure, are often forced to make decisions shorn of this valuable context.

In recent decades the diffusion of ideas between historians and policymakers has been enhanced by networks such as History and Policy, and events such as witness seminars which bring together influential figures such as politicians and civil servants to discuss events of historical interest. However, more remains to be done to facilitate these exchanges and bring historical experience to bear on major issues of contemporary relevance.

Health is an area of public policy where historians can make significant impact. Secular changes, for example the changing patterns of disease, rising health expenditures, and ageing populations beg a long-term historical view. Pressing problems facing health policymakers, such as perennial winter health crises, budget cuts, and administrative reorganisations may appear to be 'of the moment', but they can bear the imprint of former policy processes that historians can uncover. The various configurations health systems take, and the principles on which they stand, are often taken for granted by members of the public and observers in the media; moreover, they are often considered sacrosanct, limiting the scope of public and academic enquiry. Historians can bring a unique perspective to health policy, addressing questions such as why health services are organised and financed the way they are; what constitutes public health, and how it is demarcated from other aspects of health care; and the role of policy actors such as international and voluntary organisations. Working alongside (other) social scientists, historians thus have a valuable role to play in the policy process.

These considerations informed a seminar of the Academy of Social Sciences held in London on Monday 4 December, 2017, with the aim of discussing major historical issues in health policy. Organised by Professor Linda Hantrais, FAcSS (LSE), Professor Virginia Berridge, FAcSS (London School of Hygiene and Tropical Medicine (LSHTM)) and Professor Susanne MacGregor, FAcSS (LSHTM/Middlesex University), and sponsored by Taylor & Francis, the seminar was organised as part of a series on international and multi-disciplinary perspectives on evidence-based policy. Participants were drawn from across the UK and included prominent public health researchers as well as historians.

Conversation 1: Public Health

The first half of the seminar was dedicated to 'conversations' between historians and public health researchers that teased out major themes in the history of health policy. The first of these, on the subject of public health, was chaired by Virginia Berridge and brought together the historian Alex Mold (LSHTM) with the Professor of Public Health, and former president of the Faculty of Public Health, Alan Maryon-Davis (School of Population Health Sciences, Kings College London).

The first major problem that dominated the conversation was conceptual: how public health can be defined. Mold emphasised the heterogeneous nature of public health as a set of services, practitioners, and population-health problems, while Maryon-Davis distinguished between public

health as a set of problems and challenges, and a discipline and body of knowledge that extends back to the nineteenth century.

The second issue was historical: how public health has changed over time. Mold teased out three major historical trends: changes in the threats confronting populations, such as the epidemiological transition; changes in the location of public health, such as its movement from local government to the NHS in 1974, and back again more recently; and changes in public health's philosophy and outlook, for example the broadening in recent decades to encompass a range of voluntary organisations and private companies in addition to doctors and politicians. Maryon-Davis explained that while public health is relatively small at a local and national level in comparison to other to health services, its cumulative effect can be significant. Public health can act as an agent provocateur, harnessing the weight of public opinion to achieve major goals, such as smoke-free spaces.

Another key question was the relationship between public health, 'the public', and policymakers. Mold argued that it is only recently that policymakers have begun seriously to question how they engage with the public (or publics), while Maryon-Davis reiterated that for a long time, public health has had a community advocacy role, for example through the work of health visitors.

Ultimately, both Mold and Maryon-Davis saw a positive role for history in informing public health policy. In recent years, particularly since the Brexit vote in the UK and the election of President Donald Trump in the USA, the idea that academic or professional expertise has been marginalised has become attractive. However, this is over-played, and alongside researchers from other disciplines such as social anthropology and behavioural economics, historians continue to play an important role in informing policy. Crucially, this should extend beyond simply pointing out where mistakes have been made, or indicating where things have happened before. Historians have to make concrete recommendations policymakers can follow. The challenges facing public health in the future are daunting: not only the immediate problems of political populism, but climate change, genomics and antimicrobial resistance. New institutional mechanisms are urgently needed that historians can use to inform policy in these emerging areas of global concern.

Conversation 2: Health Systems

The second conversation, chaired by Professor Sally Sheard (University of Liverpool), brought together the historian Martin Gorsky (LSHTM) with the Professor of European Public Health, Martin McKee (LSHTM) to tackle the subject of health systems.

Like public health, the 'health system' as an object of study is frustratingly nebulous and ill-defined. McKee advanced the World Health Organisation's official definition, 'all organizations, people and actions whose primary intent is to promote, restore or maintain health.' This remains the best accepted definition worldwide, but in practice, 'health system' has a variety of meanings and depends on the question asked. Gorsky explained how the idea of the health system that we are familiar with today first emerged in the 1960s, as a result of the work of health services, cybernetics and operational researchers. However, the roots of this idea extend back to the inter-war period (1918–1939), and the work of international organisations such as the League of Nations Health Organisation, which began to collect data around the administration of health services in addition to health outcomes, such as mortality.

Indeed, the idea of the health system has developed in conjunction with a whole raft of important metrics. Arguably it was only with the WHO's *World Health Report* in 2000 that the idea of the health system fully crystallised, defining how responsive a system is in relation to the needs of its users, and the societal distribution of factors such as health outcomes and financing. Health systems are frequently discussed in relation to ideal types such as the British NHS, the USA, where privately funded care is dominant, and the Bismarckian model of social insurance which characterises many European countries. However, while the NHS has some distinct qualities, such as universalism and

freedom from expenditure at the point of use, both McKee and Gorsky cautioned against the uncritical acceptance of these ideal types, arguing that most health systems are heterogeneous and researchers should embrace the full panoply of financial and organisational arrangements that exist around the world. It is only natural that in Britain, the shadow of the NHS should loom large over health systems research. Yet, international comparison could yield vital policy lessons (for example, pointing out how the British NHS is underfunded), and McKee pointed out how there is a depressing ignorance of alternative models of health care, especially those that exist on the continent. In studying the history of health systems, historians should endeavour to question commonly-held beliefs, such as that the NHS was universally regarded as a positive development at its inception. On the contrary, revisionist historians have shown that the pre-NHS health system in Britain had a high level of public support and was often successful in delivering good health outcomes.

Table discussions

In the second half of the seminar, participants split off into smaller groups to consider various sub-themes.

Table 1, chaired by Susanne MacGregor (LSHTM/Middlesex University), focused on public health. Reflecting on the conversations earlier in the day, the group deliberated on how historians can bring their expertise and perspective to bear on contemporary public health policy. As one member of the group remarked, the difficulty is that historical contexts are often highly specific, and thus not easily transferable from one policy environment to another, or applicable to present-day issues. Other members of the group countered that this is not necessarily a disadvantage. The great strength of the historical perspective is that it can remind policymakers that things were not always the way they are now, and that they have a choice: in different times and places, things have been done differently. Historians can also show where wrong decisions have been taken, and indicate how these decisions can be reversed or repaired. For example, the imposition of austerity measures by the British government since 2010 has had significant consequences for health: life expectancy has plateaued. Yet politicians could easily have taken a more equitable path, as suggested by measures taken under periods of austerity in the past, such as the creation of the NHS in 1948, or Roosevelt's New Deal in 1930s USA. There are many caveats involved in transferring policy 'lessons' from one historical, social and political context to another. However, it is by no means impossible to learn from experience elsewhere, and by also embracing an international comparative perspective, historians can indicate what was successful about a particular intervention in another country. Potential themes for research explored by the group included the history of patient involvement in public health, a historical comparative study on the impact of austerity on health, public health whistleblowing, and the changing use of data over time, and attitudes towards it.

Table 2, chaired by John Stewart (Glasgow Caledonian University), discussed health systems. The table debated the appropriateness of the WHO's definition of 'health system' and the extent to which it implies organisation; the effects of particular funding models on a system's ethos and outcomes; the role of voluntary and religious organisations; and the role of individuals such as William Beveridge, Brian Abel-Smith or Charles de Gaulle in shaping health systems. Conversation pivoted around three points of contention: Is it possible for a health system to be created from a blank slate, or is it invariably a process of reconfiguration? Are charismatic individuals necessary to give direction to health systems — for example so-called 'policy entrepreneurs' — or are transnational knowledge networks, epistemic and international policy communities more important to facilitate policy learning? Finally, to what extent are health systems beholden to their history, or previous modes of organisation and financing, and to what extent are they able to break free and explore new patterns? In relation to the last point, group members pointed to the importance of 'path dependency' in explaining the various models of health system organisation around the world. The existing pattern

of health care services in countries, the way they are financed, and their governing ideologies and norms are all explained in part by historical processes, the existence of vested interests keen to maintain the status quo, and the considerable inertia or costs associated with transitioning to another pattern. Of course, in various times and places, and in specific contexts, health systems have undergone profound transformations: witness the emergence of the NHS in 1948, Medicare and Medicaid in 1960s USA, and the movement towards a pluralistic health service model in Central and Eastern Europe following the collapse of the Soviet Union. The group showed that historians are well placed to deconstruct the factors that might bring about a sudden change in trajectory, for example war, decolonisation, economic depression, or market-led ideology (structural adjustment). They may also highlight the wider conditions of change, such as the presence of strong civil society organisations and labour movements.

Table 3, chaired by Virginia Berridge, focused on the impact of evidence-based policy on the health sciences. The discussion encompassed the various ways evidence is generated across the health sciences and the differing usages of terms such as 'co-production' and 'co-creation'. The group also discussed the implications of the push for positivistic understandings of implementation, as seen in the discourse around 'implementation science'. Varying standards around evidence and the many different ways it is marshalled across the health sciences can lead to significant professional tensions. For example, the hierarchies of evidence approach in evidence-based medicine can inhibit public health interventions since it may be easier to generate robust RCT-type data on the effectiveness of drugs and surgical interventions than data on complex, 'real world', public health interventions. There are also difficulties in generating evidence for 'preventive' interventions compared to those designed to improve or restore health following an illness or injury. Thus the way evidence is generated can impact the jurisdictional claims of particular fields, such as public health. However, these tensions vary depending on the level of the health system in question; in local authorities, for example, evidence can be just one of the many competing concerns guiding policy.

Table 4, chaired by Anne Jamieson (Birkbeck), examined ethics, rights, challenges and risks in health policy. The group discussed these themes, and the important trade-offs that exist between them, through the lens of existing research by members of the group. The issue of risks versus rights, for example, is a key element in alcohol policy, as reflected in the work of James Nichols and Dominique Florin. In Martin Gorsky's work the issue of rights is central to the development and strengthening of health systems. Countries such as Brazil, for example, have advanced the idea of universal access to health care as a basic right of all citizens. The need to reduce risks, such as falls, and the right to a quality of life can be a trade-off in the care of older people, as reflected in Anne Jamieson's work. The discussion proceeded to explore the relationship between these areas of study along other analytical dimensions: the location of health services in central or local government; the conditions that give rise to structural changes in health systems; and the nature of society, whether it is oriented to solidarity or fragmentation. Potential topics for research included gun control in the USA, international approaches to alcohol management, and the balance between health and social care and their funding.

Outcomes

The afternoon highlighted the considerable conceptual and practical challenges that historians face when studying health, as well as the significant opportunities accompanying the historical perspective. Working alongside other social scientists, historians can help bring public health and health systems into focus by elucidating the social, cultural, political and economic conditions that have shaped them. For example, historians can inform current policy debates by exposing the rationales behind past decisions, the problems and constraints faced by policymakers in the past, and the wider influence of

other agents in the policy field. Given the centrality of path dependency to health systems, historians can highlight the future trajectories they might take by tracing their historical path.

The turnover of politicians and civil servants as part of the ordinary operation of government means that institutional memory can be lost and historical experience is likely to be absent from policy decisions. This leads each generation to 'reinvent the wheel'. Moreover, continual government reforms may inhibit the accumulation of a shared *esprit de corps* in healthcare organisations and an understanding of their aims and purpose. Historians can thus enhance the policymaking process by being party to decisions and explaining the background to current policy debates. None of this is straightforward. In order to bring this aim into fruition, there is a need not only for a more formal mechanism to bring historians into contact with policymakers, but also for existing mechanisms, such as History and Policy, to be exploited to the full.

Dr Christopher Sirrs is Research Assistant at the Centre for History in Public Health, London School of Hygiene and Tropical Medicine. His current research focuses on the intellectual and policy history of health systems, as part of the Wellcome Trust Investigator Award 'Health Systems in History: Ideas, Comparisons, Policies'. For further information please see http://systemshistory.lshtm.ac.uk.