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Reply

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I thank Larry Brown and Alan Maynard for perceptive comments on my article. The three of us urge advocates of improved population health to pay attention to determinants of policy as well as to determinants of health. If some of them do that, they will notice that leadership in policy making for health is shifting from the supply to the demand-side of the health sector.

During the twentieth century, the agendas of leaders of the medical profession and its allies became the principal determinants of most health policy in many industrial countries. The demand-side of the health sector allocated resources to priorities set by suppliers of scientific knowledge, services, and professional education.

Two decades ago, I described the policy model for the supply-side dominance of health policy (Fox, 1986). According to this model, which I called 'hierarchical regionalism', resources and information with which to prevent, diagnose, and treat illness should flow down a hierarchy of organizations and practitioners within particular geographic areas. Teaching hospitals and the medical schools and laboratories associated with them should be at the top of each regional hierarchy, primary care practitioners the bottom. Hierarchical regionalism justified hospitals and medical specialists spending most of the funds allocated to the health sector in ways determined mainly by clinicians.

Leaders of organized medicine and public health endorsed the premises of hierarchical regionalism. They agreed that scientific advances caused most improvements in health and that most scientific knowledge would be translated into technology delivered to individual patients. Because science drove policy, and doctors understood science and its applications, policy makers who purchased and regulated health care should defer to doctors and their allies.

Each of these professional interest groups took exception to an important implication of these premises. Clinicians resisted the inference that because academic institutions produced science and professional education, they should be responsible for the quality of care and hence for licensing and disciplining doctors and certifying them as specialists. Most public health professionals wanted more resources to be allocated to preventing disease in populations as a complement to preventive services delivered in clinical hierarchies. In the politics of policy in every country, clinicians won, and advocates of more spending for public health lost.

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Public support of the dominance of the supply-side in health policy was strong and broad for most of the twentieth century. Advancing science seemed likely, eventually, to control or cure most diseases and to relieve considerable pain and suffering. Proponents of hierarchical regionalism took credit for declining death rates from most infectious diseases. They were optimistic that science would eventually lead to improvements in care for chronic disease, as the discovery of insulin had exemplified for diabetes in the 1920s.

Hierarchical regionalism has been eroding since the 1970s. The rising cost of health care was the major cause of loss of faith in the model. As policy makers struggled to contain costs, they noticed that more spending for personal health care services was not producing significant improvements in population health. They also noticed that hierarchies of hospitals and clinicians were becoming flatter as the skills and technology to diagnose and treat disease were increasingly available in primary care or outpatient specialty practice or in community hospitals. Policy makers also began to worry that an aging population would soon accelerate the increase in the cost of care.

By the 1970s, moreover, a few policy makers (and a small number of health professionals and members of the general public) noticed growing evidence of the significance of other determinants of health than health care. This evidence suggested that policy could reduce, for example, diseases linked to tobacco use, inadequate diet, and lack of exercise.

Most policy makers were reluctant to challenge supply-side defenders of hierarchical regionalism. Leaders of the medical profession maintained considerable prestige. Proposals to close or consolidate hospitals or restrict access to particular interventions frequently sparked public protests about discrimination and rationing. As a result, policy makers tried to contain costs through modestly confrontational policy for budgeting and reimbursement and began to inquire about the appropriateness, effectiveness, and efficiency of services.

Policy makers lacked tools to distinguish between beneficial interventions and those that were ineffective or redundant. Researchers gradually provided such tools. Between the 1970s and the 1990s, researchers who studied health services devised statistically powerful methods to evaluate the effectiveness and efficiency of interventions intended to improve both health care and population health more broadly.

Policy makers (in the United States, in large businesses as well as government) have rapidly increased their use of these methods to inform decisions about resource allocation. Regulators of access to pharmaceuticals were the first to apply the new methods (in Australia, British Columbia, New Zealand, and Norway, soon followed by the United Kingdom and the United States). The intense and well-funded antagonism of the pharmaceutical industry to these regulations in countries around the world is perverse evidence of their success. Many clinicians and providers are, moreover, improving the quality and safety of care in response to anxiety about potential demand-side regulation.

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It is too early to know if the authority of the demand-side will continue to increase. Two sets of evidence justify optimism. The first is that the findings of 'evidence-based health research' are increasingly persuasive to policy makers, the media, and health professionals. The second is a growing body of rigorous research on the effectiveness of interventions to address other determinants of health than personal health care (Task Force on Community Preventive Services, 2006).

Resistance to the authority of the demand-side of the health sector is, however, substantial. Although policies that sustained hierarchical regionalism have been modified, the institutions created by those policies and their suppliers still have considerable cash and authority. The professional culture created and reinforced by hierarchical regionalism is strong. Evidence of the ease with which the pharmaceutical industry creates or co-opts organizations that claim to speak for consumers suggests that many members of the public remain comfortable with supply-side dominance.

Larry Brown, Alan Maynard, and I no doubt differ in our guesses about the near future of health policy. I hope we agree, however, that the assertion of demand-side authority over policy to make care more effective and efficient is likely to be in the public interest.

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