

Book Reviews



Ageing and Public Policy in Australia. By Sidney Sax. Allen and Unwin, 1993. xii + 179pp. Paperback A\$21.95

The 1980s were a period of rapid development in gerontology and ageing policy studies around the world. In writing about Australian developments Dr Sax describes his purposes: 'This book is not meant to be a technical document, but one designed to raise awareness and stimulate critical debate about the circumstances of older Australians and the policies that affect their wellbeing' [p xi].

The book reviews and synthesizes the Australian policy developments and academic research on ageing of the last two decades, as well as some of its international influences. It is a book that can be read easily cover-to-cover as well as used as a reference by dipping into it for themes or areas of interest.

The book is exceptional for another reason. Unlike women's studies where men rarely write, ageing studies are dominated by the young and middle-aged career academics and bureaucrats rather than by writers of mature years. Sax notes the 'genteel' and 'polite' character of reports on conditions of the aged as a consequence of the fact that 'They have been prepared principally by middle-aged people looking toward the threshold of old age' [p. 10]. International readers will already have a hint that Sax is a rare example of a writer of mature years writing about his own age group. His background is that of a medical doctor, who played a central role in the development of community health and welfare policy throughout his career in Australia. Sax notes the gap between people like himself and the popular images of the elderly: 'Such old persons come from a world seemingly different from that peopled by many of the elderly subjects reported in the popular press' [p. 4].

The book covers health, long-term care and welfare policies for Australian elderly. The material synthesized shows a strong influence of Sax's central position in policy development and a post-retirement career at the Australian National University (ANU) and the Australian Institute of Health and Welfare (AIHW). He reports much of the work from the ANU Ageing and the Family Project and his health and demographic statistics reflect his exposures to the work at AIHW. These inputs, as well as others, give a comprehensive character to the issues covered in the book. The text is not as well organized into sections as it could have been but it is well indexed.

Sax's lifelong commitment to issues of social justice is reflected in the way policy issues are covered. He notes the significant contribution of socio-economic status to health and life expectation [p. 50] and returns to his theme in his final chapter discussing public-health factors in creating a 'good old age'. He does not, however, emphasize the social to the neglect of medical factors: 'Modern surgical methods and modern therapies not only improve the quality of life of older patients but may prevent or limit premature admissions to residential care' [p. 75]. The book is balanced in its treatment rather than committed to a particular line of argument or interest-group point of view.

The coverage of health and disability, as well as policy issues, will be of interest to an international audience. The issues and style will provide a good insight into research and policy on ageing in Australia.

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Medical Care and the Health of the Poor (Cornell University Medical College Eighth Conference on Health Policy). Edited by David E. Rogers and Eli Ginzberg. Westview Press, 1993. vii + 144pp. Hardcover US\$49.50

The focus for the Cornell conference on health policy was chosen because of a feeling that the issue was the root cause of the dismal US showing in many indices of health. Invited papers, published in this volume, were discussed at a two-day conference. However, it is quite clear from a brief summary of the entire conference, that discussion of the papers yielded a far more spirited and critical assessment of the US scene. It is the discussion that should have been published; this is an instance where institutional conference rituals defeated aims. The paper-writers were at a disadvantage because they were asked to review issues from different specialist viewpoints. Given the complexity of determinants and the very limited role that medical care can play in influencing societal origins of poverty, they had little scope for any useful commentary.

In by far the most thoughtful and useful contribution, the economist Fuchs addressed fundamental questions on the relationship between poverty and health, dwelling especially on factors influencing health status and access to medical care. He explained the failure of the US health-care system to provide adequate services and favoured cash transfers to the poor instead of the existing Medicare and Medicaid programs. Fuchs asked why Americans are less willing than those in other industrialized nations to subsidize medical care for the poor—through what he termed ‘the weakness of *noblesse oblige*’.

From fairly Olympian heights the sociologist Starr considered how much inequality in health status and in access to health services a democracy can tolerate. He believed a universalist (nationally comprehensive) system of health-care insurance is not a commitment of democracies. The latter will permit a reasonable degree of access provided the poor have a basic level of services available to everybody. Accordingly, he proposed a two-tier system with the rich paying for additional services in the upper tier.

Hamburg, the Commissioner of Health for New York City, reproduced an official speech about tuberculosis increasing rapidly in the poorest districts. She blamed massive funding cuts during the 1980s for the current situation, but thought it was controllable by an organized campaign (along lines similar to the Australian national program which was terminated in 1966).

The only non-American contributor was Black, who as chief scientist for the UK Department of Health and Social Security, chaired the committee that produced the Black Report, which the Thatcher government tried to suppress. This report provided evidence that nearly 40 years of the UK National Health Service had not reduced social inequalities in health status. Black’s paper stands out through being firmly based on official statistics, and although he made some telling general comments on the health consequences of poverty and political ideology during the 1980s, he was not prepared to tell the Americans what they should do.

Two papers by clinical investigators centred, respectively, on hypertension and arthritis, emphasized the various constraints and barriers to obtaining medical care and maintaining effective personal regimes of treatment. Even those who received subsidized care faced financial barriers in the form of co-payments for federal Medicare (aged) services and even, in some states, for Medicaid, which

covers ten per cent of all Americans as a means-tested federal and state funded program targeted at the welfare population. As Rowland explains, these forms of social insurance are seriously defective for assuring access and an adequate quality of medical care among the poor.

Miller, a paediatrician, was enthusiastic about specific programs for poor children. He supported what a 1990 US House of Representatives Select Committee on Children, Youth and Families recommended as cost-effective initiatives to improve the health, development, nutrition and well-being of the nation's children. These included educational, employment, training and cost-supplementation programs.

This collection of papers does not provide any guide to advanced thinking about health and poverty nor any credible approach to solutions for enormous problems with the health of the US poor. Part of the reason is the traditional professional conference culture; it cannot cope with social issues where specialists have to focus on dealing with adverse outcomes of complex societal processes. Clinicians were aware of social determinants influencing advanced diseases among the poor but because they were in the straitjacket of a medical conference all they could suggest was tinkering around with regimes designed for the treatment of individuals.

In fact, tinkering around with existing processes and arrangements appeared to be the generally preferred pathway towards solutions. And this is what makes these papers so depressingly unhelpful. The writers seemed to be suffering from what Bloom (1988) described in his book, *The Closing of the American Mind*. Indeed, the intellectual timidity of the authors (excluding Fuchs if you read between the lines) is quite shattering. These papers were delivered while the state of Oregon was conducting a public inquiry into how to ensure that all its citizens received an adequate level of health care, when forces were gathering to elect President Clinton on a platform that included major health-care reforms and after numerous analyses had appeared on how social inequalities had widened in the US during the Reagan administration.

None of this is echoed by the contributors. They urge cautiously that conditions for the poor must change but generally in a piecemeal and incremental manner. Overwhelmingly favoured are special remedial programs, always imposed on the poor by experts (no hint of negotiating solutions or community participation in these pages). Race and gender issues of the poor are ignored or treated in a deterministic way, as with African Americans being more prone to hypertension. There seems almost a determination to avoid mentioning any of the considerable body of theoretical and empirical work done in other industrialized countries. Even Fuchs quibbles about the use of social indicators to measure health inequalities, despite Navarro having demonstrated that it is possible to construct socioeconomic status, race, and health differentials from US data (Navarro 1990).

A strong impression is left from reading these papers that most of the writers believe any structural changes involving whole-society efforts to raise the health status of the US poor will conflict with an immovable American ethos on social institutions. And that is deeply disturbing because as Samuel Johnson put it, 'A decent provision for the poor is the true test of civilisation'.

References

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The Social Basis of Health and Healing in Africa. Edited by Steven Feierman and John M. Janzen. Berkeley: University of California Press, 1992. xviii + 487pp. Hardcover US\$17.00

This volume consists of 18 essays which examine the social, political, and economic contexts of health, disease, and therapeutic practice in Africa. Many take an historical perspective as well, with material ranging from the pre-colonial to post-colonial periods. Indeed, the editors argue that health and healing are part of 'historically continuous streams of interrelated theory and practice' (p. xvi) and thus cannot be understood when regarded simply as 'traditional' or as 'modern' medicine. Moreover, without an understanding of the changing contexts—social, political and economic—in which contemporary health practices are grounded, health programs in Africa will have limited success. The inadequacy of biomedical interventions alone, in the face of socioeconomic disparities and political discrimination, is depressingly illustrated in several of these essays.

The volume is divided into three parts. Part I consists of an introduction that examines alternative approaches to earlier ethnomedical studies of health, disease, and cure in Africa which tended to limit analysis to discrete ethnic groups. However, as Janzen shows in his study of the Lemba cult of western Equatorial Africa (Chapter 7), cult practitioners and followers came from a wide area, crossing several ethnic, as well as national, boundaries. The idea that healing practices relate to a timeless and culturally-specific world view is similarly undermined by these essays. Rather, it is argued, perceptions and practices of health and healing are part of broader social, political, and economic processes which are continually being reassessed and contested, for as the editors observe, 'Struggles for health are tied to society's central struggles' (p. 10). These struggles may include those between pre-colonial chiefs and healing-cult leaders over local political authority, between European colonial officials and African leaders over public health rulings on housing segregation, or in the post-colonial period, between western-trained and indigenous doctors over claims of medical legitimacy and government funding.

In Part II, a history of 'patterns of ill health' in Africa is sketched out through the use of demographic data on mortality, fertility, and migration which document changes in African populations from the late nineteenth century through the twentieth century. Despite the dearth of vital statistics for the period, it is generally agreed that there was a decline in population from approximately 1880 to 1920 after which the population steadily increased. In the introductory essay to Part II, various explanations for this phenomenon are discussed including increased transportation and migration, forced resettlement, and changing family and gender relations. The five essays that follow explicitly address the social context of illness and of population decline in several different areas. In their comparative study of demographic data from pre-colonial Central African Republic and contemporary Burkina Faso, Cordell, Gregory and Piche examine connections between mortality, fertility, migration, state policies and class structure. Malnutrition and famine also predisposed individuals toward disease, although these conditions were often related to social and political inequalities. Vaughn discusses the ways that particular social groups differently experienced the famine of 1949 in Nyasaland (present-day Malawi). Dawson shows how people's movement away from famine areas led them to congregate in particular places, contributing to a devastating smallpox epidemic in early colonial Kenya. In essays by Packard and by Marks and Andersson, the spread of tuberculosis in South Africa is related to malnutrition and poverty associated with work in the mines and with government-supported racial discrimination.

Part III consists of essays based on specific ethnographic studies of therapeutic practices. While these practices display considerable continuity over time and area, they also show a good deal of variation. These differences are reflected in the ways that some of the authors have chosen to

characterize medical knowledge and practice in particular societies. Some (for example, Prins, Chapter 13) describe well-defined medical systems of cause and therapy, whereas Last (Chapter 16) emphasizes the improvisational quality of prevailing medical practices in certain societies. The authors of these essays tend to agree, however, on the close connection between politics and medical practice. The political control of medicine by the state or other centralized polities—through differential funding and through professional licensing, for example—may be complemented (or countered) by more decentralized, local practices including participation in spiritual healing cults and individual therapeutic strategies.

In the introduction to Part III, the early historical intersections of African, Western, and Islamic medicine as well as the later introduction of colonial allopathic medical practices are briefly discussed. The historical nature of these varied and changing medical cultures is emphasized by grouping these essays into pre-colonial, colonial, twentieth century, and post-colonial periods. The first three essays examine the ways that medical practice is related to religious belief and practice. Abdulla documents the diffusion of Islamic medicine in northern Nigeria. Janzen discusses the history of the Lamba cult in West Equatorial Africa from the mid-seventh to the late-nineteenth century. Waite considers the relationship between the leadership of kings, priests, and chiefs and public-health practices in pre-colonial East-central Africa.

The section on colonial medicine continues this examination of the relationship between authority, political and spiritual, and medical knowledge and practice. In his essay on medical knowledge and urban planning, Curtin examines how prevailing ideas about malaria transmission shaped colonial African cities.

The continuity of African concepts of disease and curing, despite the introduction of Western medicinal practice by missionaries in Tanzania, is discussed by Ranger.

In the section on twentieth-century medicine, specific models of medical systems are related to conceptions of disease and curing practices for particular areas. Greenwood documents the overlap of two distinct medical systems, humoral and Prophetic, in Morocco.

Sindzingre and Zempleni outline local explanations for recurrent disease and subsequent therapies practised by the Senufo people of Côte d'Ivoire. The importance of divination in therapeutic practice is noted in several of these essays. For the Lozi of Zimbabwe, it serves the need to identify 'core areas' of affliction described by Prins. In discussing Zulu women diviner-healers in South Africa, Ngubane emphasizes the significance of patient-doctor communication and of the diviner's social network in affecting cure. Davis-Roberts's discussion of the illness of a young Tabwa girl in Zaire illustrates how diagnoses made by diviners may derive from the social domain as well as physiological ones. Last describes the therapeutic practices of rural Hausa diviner-healers in Northern Nigeria who do not appear to draw upon any overarching conceptual system of medical knowledge.

The two essays in the final section on post-colonial medicine consider government health programs in Kenya and in Sierra Leone. Mburu's essay on the inequalities in health care available in Nairobi emphasizes the role of class and political power in obtaining health services. The role of the state in legitimating various forms of healing—whether indigenous or Western—is discussed by MacCormack, who discusses a model for integrating services offered by bureaucratically organized medicine and 'traditional' medical practitioners.

These essays provide an excellent introduction to the varied health practices in Africa. While many of the essays have been published elsewhere, having them together under one cover allows the reader access to abundant material on ideas and practices relating to disease and conveys a sense of the diverse options of health care which exist in the continent. There are a few, small complaints, mainly

with copy editing, as in the bibliography where some dates are omitted (Packard et al.) and names are misspelled (Ruzicka, not Ruzika); Map 1 lists Lagos as the capital of Nigeria.

These essays forcefully demonstrate that aspects of the political economy and of social organization must be considered when investigating the basis of ill-health and healing in Africa, a point which has important policy implications for health-program implementation. For this reason, it is unfortunate that the editors did not make some attempt to address the issue of HIV-AIDS research in Africa, perhaps in a brief concluding section. While they note this omission in preface remarks, an essay addressing general issues of HIV-AIDS research in Africa (see Packard and Epstein 1991) might have been included to good effect. These essays provide examples of cautionary ironies: for example, in Zaire, colonial officials forced villagers living on hill-top sites to move to *trypanosomiasis*-infected lowlands for health reasons (Ford 1971). Such examples underscore the sometimes unintended consequences that result when social, economic, and political contexts of health are not taken into account.

References

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