

**Compliance, Community Participation and Consumerism A
Sociologist's Contribution to Health Policy Analysis**

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Published

2005

Journal Title

Professorial Lecture - Thursday 28 July, 2005

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Compliance, Community Participation and Consumerism:

A Sociologist's Contribution to Health Policy Analysis

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Professorial Lecture

Thursday 28 July, 2005

GRIFFITH UNIVERSITY

Gold Coast Campus



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'It was humbling to see how the suggestions of ordinary people were often far ahead of those of the leaders.'

Nelson Mandela 1995

Introduction

The lecture will follow a chronological sequence as I have been researching the role that patients, communities and consumers have played in shaping health care services for over twenty years. I will be referring to three studies in particular: First, an ethnographic study of cancer treatment in a Sydney hospital, undertaken in 1982 (Short, 1985; 1986); secondly, a case study of the Illawarra Cancer Appeal-a-thon, completed in Wollongong in 1988 (Short, 1989), and thirdly, analysis of consumer activism in the health policy process. The third study was conducted over the decade of the 1990s with a focus on the genesis and development of the Consumers' Health Forum of Australia; the national voice for health consumer organisations in Australia (Short, 1998a). This sequence is being followed with the intention of showing how a sociological understanding of patient and public participation in health care has developed and how this analysis has relevance to sociological studies in health care more broadly, as developed further in my co-authored book, *Health Care and Public Policy*, now in its third edition (Palmer and Short, 1989; 1994; 2000).

Studying Patient Compliance in a Sydney Teaching Hospital

The first study focused on patient decision-making and the power relation between doctors and patients in the cancer treatment unit of a Sydney teaching hospital. It was an ethnographic study; my intention was to study the culture, the attitudes and values of professionals and patients within a high-technology teaching hospital environment. The research methods used included participant observation for three months, during which time I acted in an observer-as-participant capacity, semi-structured interviews with patients, radiotherapists, radiographers, nurses and other health workers, and

examination of medical records. Thirty-nine interviews were conducted and in the course of the research over 400 doctor-patient consultations were observed. I wanted to know what the patients were thinking and how they made their decisions about surgery, radiotherapy, chemotherapy and so on. I wanted to write it down for them.

It was relatively easy to analyse the power relationship between doctors and patients in this context. In the overwhelming majority of consultations the patients accepted the advice of doctors and followed their orders. In the course of the fieldwork there were less than a handful of incidents in which the patients questioned the advice or directives of their doctors. I summed up the nature of the power relation in the terms 'trust and obey'; patient compliance.

Patients appeared to follow their doctors' orders in a seemingly unquestioning way, even when doctors were recommending long courses of chemotherapy or radiotherapy which meant major upheaval to their lives and to the lives of their families and friends. I give two examples from consultations:

Patient: 'I have got faith in the doctors ... the doctor really makes the decision.'

Patient: 'I don't really know which doctor I'm under really; but yesterday a group decided that I needed radiotherapy.'

In interviewing patients I was attempting to examine the attitudes and values which lay behind this trust and obedience and I found that the force of medical authority rests on three bases of legitimation. First, patients trust their doctors because they believe that they have a monopoly on scientific knowledge and technical expertise in cancer treatment. This is the technical basis of medical authority. One doctor—patient interaction illustrates this vividly:

Patient: 'You're the boss now. I'm not.'

Doctor: 'That's the way we like it.'

However, it became apparent that this was not the only source of legitimation because patients trust doctors more than other technical experts such as engineers or accountants. Patients believe that doctors will work in a benevolent capacity. That is, that they put the interests of patients before their own. This belief in the service ethic of the medical

profession forms the ethical justification for medical authority. To illustrate with an excerpt from the field notes:

Patient: 'You have to trust them that it's doing you good.'

Patients did not evaluate the content of doctors' orders, nor did they weigh up the pros and cons of their decisions. They trusted doctors because they believed that doctors would put patient interests before their own personal or professional interests.

This trust in the medical profession is not unique to contemporary Australian society, however. Trust in healers in European culture has been traced to faith in Aesclepius, the God of healing in ancient Greek mythology. A serpent entwined around a staff --the staff of Aesclepius --is a symbol of the traditional power of healers, as appropriated by the Australian Medical Association in its logo. The legitimation of medical authority therefore has historical or traditional roots. Interestingly, the religious basis of medical authority was still evident in this case study. There is still a religious aura in cancer treatment. For example, one patient addressed a letter of thanks to the 'Angels at the linear accelerator'. Doctors, too, were aware that they were expected to act like Gods in some ways, as is evident below:

Doctor: 'I would probably have reason to express doubts because I'm not God almighty.'

Patients often expect doctors to know everything and to be able to fix everything. As one palliative care specialist has written, '... it is easy to become cast in a Godlike and idealised role by patients and family ... and after all if they tell us often enough how great we are, we do begin to believe it' (Simpson, 1982).

In most cases doctors presumed that patients wanted every treatment that was technically possible. The situation in the cancer unit paralleled the comment made by Solzenitsyn's (1971, p. 157) main character in his allegorical novel, *Cancer Ward*.

'...you make the logical deduction that I came to you to be saved at any price! But I don't want to be saved at any price! There isn't anything for which I'd agree to pay any price!'

In defining the way patients' problems should be managed, doctors generally assumed that what could be done technologically, that is, with surgery, radiotherapy and chemotherapy, should be done.

Decision-making in cancer treatment in this case study can be summarised in two statements. First, patients trusted doctors and obeyed their doctors in a seemingly unquestioning way. Secondly, the force of medical authority, and patient compliance, stems from three interrelated sources of legitimation. Patients trust and obey because the medical profession has technical, ethical and traditional authority in health matters. In analysing decision-making in cancer treatment within this context it was evident that doctors were the unquestioned experts on cancer and how it should be managed.

Community participation or manipulation?

The Hunter Valley Cancer Appeal

In late 1987 I conducted a series of informal interviews with health professionals and members of the community in the Newcastle region. I conducted these interviews in an attempt to understand the background to the successful appeal for a radiotherapy treatment centre in Newcastle. My earlier study had indicated that doctors were the unquestioned experts within a teaching hospital and I was interested to see whether this authority extended outside the health care system.

In Newcastle a very successful campaign was undertaken to raise money for a radiotherapy machine at the Mater Hospital in Waratah. This appeal culminated in an NBN 3 Telethon in 1985; the local community raised \$1.4 million for a radiotherapy machine. The question I was trying to answer was: 'Where was this desire coming from?' I suppose I knew that the demand for a radiotherapy unit was not an innate desire and I wanted to understand its social and cultural origins. In my informal interviews I found that the community supported the appeal in a seemingly unquestioning way. So, trust and obey seemed to be present in the broader community. I was particularly interested to learn that a leading proponent and organiser of the appeal was a nun and senior health administrator at the Mater Hospital, the site where the linear accelerator was to be installed. In 1987, when I conducted my interviews, an on-going community appeal was being co-ordinated by the Chief Radiographer in the cancer unit at the Mater Hospital.

I concluded, therefore, that the community 'demand' for a radiotherapy machine was not independent from the work of health service administrators and health professionals. It was apparent that a senior health service administrator played a key role in putting the need for a radiotherapy machine on the public agenda in Newcastle. Once the issue was placed on the agenda the community's demand for a radiotherapy machine followed in a seemingly unquestioning way. As the Telethon dominated the public agenda on cancer, other problems such as domiciliary services or cancer screening were excluded from the policy agenda in Newcastle. In fact, in the ensuing years a simulator and a planning computer were also paid for by the Hunter Valley Cancer Appeal Committee.

The Illawarra Cancer Appeal-a-thon

As I lived and worked in Wollongong in the late 1980s-early 1990s I was somewhat surprised to find myself in the midst of re-run of the Newcastle Telethon. This study was not planned in a systematic way; in fact I collected the information and wrote it up because a number of academic colleagues and members of the community requested that I write it down for them. The story in Wollongong was similar to Newcastle, except that I was in a position to be a participant-as-observer in this instance. Methodologically, I lived through the appeal as a participant observer, monitored the local media and conducted informal interviews with health professionals, members of the community working on the appeal in a voluntary capacity, other members of the community, the co-ordinator of the Appeal and the one person who criticised the Appeal publicly.

Data from the above sources indicated that the community was united in its support for the Appeal. The Illawarra community raised \$1.5 million in an eighteen-month period with great enthusiasm. Two points should be emphasised. First, many in the community worked extremely hard to raise money for the Appeal. It appeared that these actions were consistent with the principles of 'community development', in that most of the raffles, talent quests and fashion parades were organised by sporting clubs, mothers' groups and other community groups. For example, the Warilla sports club, a small club in a blue-collar suburb in close proximity to the Port Kembla steelworks, bought \$1,000 worth of Art Union tickets. The second finding that interested me was that the community was almost unanimous in its support for the Appeal.

Only one person criticised the Appeal-a-thon in public. A social science academic, Dr Brian Martin, wrote to the local press, *The Illawarra Mercury*, and questioned the need for a

radiotherapy machine in the Illawarra. He suggested that the community's money and energy might be invested more profitably in public health initiatives such as anti-smoking or anti-pollution campaigns. Dr Martin wanted to put other issues on the agenda for public discussion. He was unsuccessful. The agenda had been set and there was only one item on it. The Illawarra community was demanding a radiotherapy machine for the Wollongong Hospital.

Whilst the medical profession and other professionals were conspicuous in their lack of public support, trade unions and workers were highly supportive. The Waterside Workers' Federation, for example, donated \$8,000. Particularly poignant was the purchase of \$1,000 in Art Union tickets by Warilla Sports Club members and guests, a small club in a blue-collar suburb near the Port Kembla Steel Works. This prompted one of the organisers to say, 'those dripping with arthritis and diamonds are seldom seen.' The poorer sections of the community contributed far more than the rich.

The most significant insight in the research came in correspondence with the Co-ordinator of the Appeal-a-thon in a letter dated 5 April 1988. In response to a conference paper I presented to the Public Health Association of Australia Annual Conference, she wrote that the community enthusiasm for the Appeal-a-thon was certainly not spontaneous and that it was more usefully seen as the result of a very successful public relations campaign on the part of the Telethon organisers, and its financiers, the Illawarra Area Health Service. For example, while the organisers were reporting overwhelming support for the Art Union in the local media, behind the scenes the organisers sent out some 600 letters and made probably three times that number of phone calls.

This information had considerable academic significance, because it showed how the Appeal organisers generated the demand for a radiotherapy machine in the community. The local media played a crucial role here by publishing many human interest stories about people who needed radiotherapy in the community and by emphasising that a cancer care centre was 'a logical part' of Wollongong's status as a blossoming city. Thus, this correspondence revealed how community perceptions and demands were manipulated by more powerful interests; in this instance administrators in the Illawarra Area Health Service.

Consumerism: The case of the Consumers' Health Forum of Australia, 1987—96

In this third study I explored consumer activism in the health policy process through analysis of the origins and development of the Consumers' Health Forum (CHF) of Australia, from its inception in 1987 through to 1996. This naturalistic study was based on analysis of relevant correspondence and policy documents, combined with key informant interviews. The Consumers' Health Forum was chosen as the focus for this analysis of consumer rights activism in health, as there is no other country in the world where an organisation such as the Consumers' Health Forum in Australia, representing community interests, has such direct access to national policy makers (Milio 1988).

The Consumer Research Development Programme

Between 1987 and 1989, the Committee administering the Consumers' Health Forum grants programme was chaired by a sociologist, Yoland Wadsworth, a well-known social policy activist and advocate of participatory or action research (Wadsworth 1984, 1989). In 1990, when Wadsworth resigned from the Committee, I accepted an invitation to join the Grants Committee, renamed the Consumer Research Development Funding Committee, and I remained a member until its demise just two years later. I then acted as a member of the editorial panel of the Consumers' Health Forum journal, *Health Forum*, until 1998.

The Consumers' Health Forum research funding programme aimed to fund only those applications which especially demonstrated and furthered a consumer perspective. Grant applicants were asked to specify how consumers would be involved in the management of the proposed project, and groups representing professional, government or commercial interests were not eligible to apply. It was, however, acceptable for consumer groups to seek assistance from another organisation in carrying out its project; the group remained eligible if it was managed and initiated by consumers and genuinely oriented to consumers. The centrality of research to the work of the Forum is illustrated in the following excerpt in correspondence from the Forum to the Department of Health (24 May 1989):

The CHF was established to strengthen the 'voice' of the consumer and community sector in health policy-decision making. We believe that a strong consumer voice is one which grounds its arguments in research. For this to be

possible, consumers must have access to the resources and education necessary to undertake research work which is of a high quality, as well as community controlled and community based.

Between 1987 and 1992 seventy-five consumer research projects were funded under the Consumers' Health Forum research development programme, to the total value of \$364 000. Groups in receipt of funds included the Congress Alukura Council, Maternity Alliance, the Schizophrenia Fellowship of Victoria and the Older Women's Network. This research, and research conducted by the Forum, underpinned the Forum's policy advocacy work in Aboriginal health, maternity care, mental health, aged care, and so on, as illustrated below.

One of the more prominent projects was conducted by Congress Alukura, an Aboriginal women's organisation based in Alice Springs in Central Australia. I quote from correspondence received by the Consumers' Health Forum (4 April 1991):

The Congress Alukura would like to share some information with the Committee that the years of political lobbying, negotiation, Aboriginal self-determination and tremendous community involvement and participation have now been rewarded. ATSIC (the Aboriginal and Torres Strait Islander Commission) have given approval for the Congress Alukura to purchase land and to construct a new building.

Congress Alukura, which represented the views of one of the most disadvantaged groups in Australian society, received funding in 1987, the first year of the funding programme, to enable Aboriginal women from remote and rural areas to attend a workshop where they discussed the notion of 'borning' and knowledge of the Grandmother's Law. Knowledge gained from this workshop, and from other sources, aided them in gaining government support for a community-controlled Aboriginal Women's Health Centre in Alice Springs. It is interesting to note, too, that the parent organisation, the Central Australian Aboriginal Congress (commonly referred to as Congress) was originally established as a political advocacy organisation, with funding from the Department of Aboriginal Affairs in 1973. The continuity between this Whitlam-led initiative, and the commitment to community development, research and policy activism evident in the Consumers' Health Forum research development programme is evident.

The origins and development of the Consumers' Health Forum of Australia

On a broader level I have studied the origins and development of the Consumers' Health Forum of Australia, established in 1987, from its early origins in federally-supported local community development work, to its current status as a 'one-stop consultation shop' for the Commonwealth Department of Health and Ageing. The CHF is the major national organisation which represents the views of community and consumer groups on issues relating to health in an imbalanced political market that systematically favours the dominant professional and industry groups (professional monopolists) or the challenging health service managers and government organisations (corporate rationalisers).

My research indicated that the forum underwent two distinct phases of development. In the first six years (1987-92), emphasis was given to the development of a strong cohesive community-based lobby which could provide the Commonwealth health authority with information and advice to act as a balance to the representations of well organised professional, industry and government groups. Since 1993, and implementation of the recommendations from the review of the Community Organisations and Support Programme however, increasing emphasis has been given to the consultative function of the forum, which is consistent with a managerialist rather than a community development approach to community participation in the health policy process.

In the 'heyday' of the reform-oriented Labor government (1983-87), progressive public servants were able to develop significant programme innovations, in the name of making public services more accessible and responsive to the needs of individuals in the community (Yeatman 1996). As financial restraint played a more important role in the public policy environment after this period, there was increasing emphasis on managerial control and accountability. This managerial climate was evident in the COSP review initiated by the Health Minister, Brian Howe, in 1990, and which led to the rationalisation of the Community Organisations and Support Programme, and to termination of the Consumer's Health Forum Research Development Programme. I have traced this decision principally to managerial concerns which focused on accountability for public funds. This study noted, too, that this concern on the part of federal health officials coincided with the professional monopolists' concern to control health and medical research funding and administration under the single umbrella of the National Health and Medical Research Council. Thus, the tide ran out on the consumer-

managed Consumer's Health Forum Research Development Programme when there was a coincidence of interests between the professional monopolists associated with the NH&MRC and corporate rationalisers in the federal health authority.

Perhaps most importantly, Neal Blewett, the Minister for Health between 1983 and 1990, wanted to win friends for Medicare, and he needed to strengthen support for the Hawke government's key economic policy, the Accord. The community development approach, which underpinned the high water mark in community activism in the health policy arena during the Hawke and Keating governments, was more appropriate for a government with an activist reform agenda (the Accord). When Brian Howe replaced Neal Blewett in the Health portfolio in 1990, the Consumers' Health Forum and other community-based health organisations were reorganised in line with the new managerialist emphasis on fiscal restraint and public sector accountability that was dominant at the time in the Australian Public Service. After 1993, Consumers' Health Forum activities shifted from community development to consultation. This scenario suggests that the high water mark of community activism in the health policy process (1987-92) occurred due to an alliance of interests between a reformist Minister (Blewett) with progressive public servants and community activists.

On the significance of the public policy context

This case study of the Consumers' Health Forum of Australia brought to light the fact that the broad public policy agenda of the government of the day plays a crucial role in facilitating and resourcing community activism in the health policy process. During the Whitlam years there was an unprecedented level of political and financial support for community development and community activism in the policy process, across the public policy spectrum, including health. The Hawke government came to power in 1983 with a reform agenda, and a commitment to control wages and prices through the Accord with industry and the unions, and to protect the social wage through initiatives such as Medicare. Industry, professional and community groups were incorporated into the policy process, and national consultative mechanisms and processes such as the Economic Planning and Advisory Council and the Consumers' Health Forum were established in order to maintain support for wages restraint, and for the social wage, and components such as Medicare. The late 1980s saw public resources devoted to consultation rather than community-based participation, and with the new managerialism

evident in the Australian Public Service, there was decreasing support for community activism in the health policy process. This study found that the existence of the Consumers' Health Forum Research Development Programme, 1987-92, represented a high water mark for community activism in the health policy process.

Given the imbalanced political market in health care, one could expect the nature of community participation in the health policy process to reflect the shifting alliances and balance of power between the three main structural interests in health care: professional monopolists, corporate rationalisers and the community. Clearly the public policy philosophy of the Accord, and the political needs of the health minister, Neal Blewett, were crucial in facilitating and resourcing the Consumers' Health Forum of Australia. Policy activism, in the form of the 'Petition of Reform' from community and consumer groups, was received sympathetically by supportive public officials in the Department of Health, and with Ministerial support, the Consumers' Health Forum, and the research grants program were born.

Perhaps Alford's (1975) structural interests' perspective is most useful in helping us to understand and explain barriers to reform in the health policy process. Medibank was progressively dismantled under Coalition governments, between 1975 and 1983, and funding for the Consumers' Health Forum research and development programme ceased due to resistance from both professional monopolists and corporate rationalisers. Thus, the conceptual framework offered by the notion of the imbalanced political market in health care goes a long way towards explaining the forces which work to *constrain* community activism in the health policy process on an ongoing basis.

When we turn to moments of progressive reform in the health policy process, as in this third case study, several ingredients appear crucial. First, a commitment by the government of the day to the reform process, in this case by the Whitlam and then the Hawke government, second, support from the Minister of the day, and in this case the role of Minister Blewett was crucial, third, support from progressive public officials, ministerial advisers and so on who champion the community activist role, and who do a great deal behind the scenes to facilitate it, and fourth, the existence of democratising social movements such as the women's health movement and the consumer rights movement, who are not afraid to challenge the hegemony of the professional monopolists in the health policy process.

Thus, this third study, of the rise and fall of community activism in the health policy process, suggested that the historical conjuncture of a reformist government, a progressive minister, sympathetic public servants and democratising social movements facilitated community activism in the health policy process. And, by the same token, it is the relative absence or weakness of these forces which constrains or diminishes the voice of the community.

Three levels of analysis: hospital, community and national

I will now draw some theoretical implications from the above three studies. Specifically, this lecture has illustrated that the sociological study of patient and public power can be undertaken at three levels of analysis (see Palmer and Short, 2000: 34-5). At the first, or microsociological, level of analysis one asks questions about decision-making within a particular organisation. In this case I asked questions about patient decision-making in a Sydney teaching hospital and found that patients obeyed doctors' directives in a seemingly unquestioning way. Trust and obey reflected the attitudes of patients in this particular study.

I went outside the health care system, into the communities of Newcastle and Wollongong within which I lived, in order to study community attitudes on a broader scale. Specifically, I was interested to find out how the public demand for a linear accelerator was placed on the health policy agenda in those cities. The demand for high-technology cancer equipment was placed on the agenda by administrators and professionals from the Mater and Wollongong Hospitals, where the machines would be housed. Once this issue was placed on the agenda other health issues such as cancer screening or health promotion were excluded. Thus, at this middle level of analysis I focused on the policy-making process and in particular the stage of agenda-setting at the local community level.

The Illawarra Cancer Appeal-a-thon study gave me the opportunity to examine how the community demand for a linear accelerator developed. I found that the community did not respond spontaneously to the issue, as previously assumed. Instead, data obtained through interviews and correspondence revealed that the Appeal-a-thon organisers generated demand for the linear accelerator through a cleverly orchestrated mass media public relations campaign. The organisers are proud of their achievement and they

embarked on further campaigns to extend cancer care facilities at the Wollongong Hospital. Wollongong is now home to a multi-million dollar Cancer Care Facility.

At the third level of analysis, the national or macro-sociological level, one is interested in the domain of health policy, and in particular understanding barriers to reform and opportunities for reform. This third study, of consumer activism in the health policy process, brought to light in the Australian context for the first time, the window of opportunity that enabled the establishment of the Consumers' Health Forum of Australia in 1986. This study brought to light social and political conditions under which the consumer voice in health care politics in Australia is more or less likely to be heard and acted upon.

More recent health policy research has shown (Short and Palmer, 2000; DeVoe and Short 2003) that changes in the broader public policy arena have created opportunities for health care reform in Australia. The most obvious health care reform occurred in 1975 with the introduction of Medibank, a universal tax-based health insurance system. This most significant health care reform was part of a broader platform of social policy reforms introduced by the Whitlam government between 1972-5. Medibank was an integral part of Whitlam's equity agenda, along with reforms in education, women's rights and so on. In both cases, with Medibank and the Consumers' Health Forum, there was an historical conjuncture between, the opportunity for change created by the government of the day and desire for reform on the part of the health policy makers. Additionally, the principles of Medibank and the Consumers' Health Forum were consistent with the philosophies of those particular governments (equity and activism respectively). There was an 'elective affinity' between the philosophy of the government of the day, and the health policy makers' perceptions of what needed to be done.

In concluding

These three studies indicate that the attitudes and expectations of patients, communities and health care consumers should not be accepted at face value by researchers. It is our role as sociologists to examine the social context within which patient compliance, and community demands for particular health care services are generated. We know that community demands are manipulated by more powerful professional, government or commercial interests. We know also that the consumer voice is more likely to be heard and acted upon in a socio-political environment characterised by the following: A

government committed to consumer and community participation in health care; a strong health minister who is committed to the reform process; supportive public officials; and the existence of democratising social movements, such as the women's health movement and consumer rights activists. Conversely, the consumer voice is less likely to be heard and acted upon in the absence of these factors. It is not our role to say what consumers should do or demand. On the contrary, I would argue, it is useful to show how patient, community and consumer demands have been constrained or manipulated as this opens the possibility for more democratic consumer and community participation in health care into the future.

I want to turn now to a poem from my favourite Australian poet, Henry Lawson. It is a poem about a bard, a traveling poet in the ancient Celtic tradition; a voice for the people whose 'lives have all gone wrong'. The setting is a hotel 100 years ago.

Will Yer Write It Down for Me?

Henry Lawson

IN THE parlour of the shanty where the lives have all gone wrong,
When a singer or reciter gives a story or a song,
Where the poet's heart is speaking to their hearts in every line,
Till the hardest curse and blubber at the thoughts of Auld Lang Syne;
Then a boozier lurches forward with an oath for all disguise—
Prayers and curses in his soul, and tears and liquor in his eyes—
Grasps the singer or reciter with a death-grip by the hand:
'That's the truth, bloke! Sling it at 'em! Oh! Gorbli'me, that was grand!
'Don't mind me; I've got 'em. *You* know! What's yer name, bloke! Don't yer *see*?
'Who's the bloke what wrote the po'try? *Will* yer write it down fer me?'

And the backblocks' bard goes through it, ever seeking as he goes
For the line of least resistance to the hearts of men he knows;
And he tracks their hearts in mateship, and he tracks them out alone—
Seeking for the power to sway them, till he finds it in his own,
Feels what they feel, loves what they love, learns to hate what they condemn,
Takes his pen in tears and triumph, and he writes it down for them.

To conclude, my ongoing research is focusing on the social structure of health care choices and constraints in Queensland, Australia and internationally. My intention is to bring to light the differential impact of Medicare both here and in other countries with comparable financial arrangements for health care. How is the emergence of a health care market affecting the structure of choices and constraints in health care in Bulgaria, and in other societies in transition from totalitarian to democratic regimes? Conclusions from our research in Bulgaria reveal that certain groups are enjoying increased choice: especially, young adults (18-24), the well educated, wealthy and those working in the private sector. At the same time disadvantaged groups are even more vulnerable in the transition period, especially the Romany minority (5%), people with a mental illness, the elderly and those living in institutions, especially children. Generally those excluded from the new labour market are worse off. I thank Griffith University for giving me the opportunity to write it down for them.

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