NOBODY KNOWS THE TROUBLE I'VE SEEN WITH THE MEDICAL MODEL OF DEVELOPMENT

Dear Adrian

Thank you for your letter (12.10.2010) in response to my complaints about the Sydney University Social, Economic and Environmental Factors Questionnaire (the SEEF Project). I appreciate your writing, because although I worked in the Faculty of Health Sciences for eleven years, advised government for ten years prior to that and also have a Phd, you are the first academic at the University of Sydney who has ever responded intellectually to the nature of the many complaints I made about work such as yours. Complaints about my rudeness were regularly made to the Dean, however, who appeared bound to take the part of the secret complainants. This is not the way to run a university because it means that greater control by the most stupidly censorious is encouraged.

At one stage my colleagues suggested I visit a psychiatrist, paid for on workers' compensation. His report stated that following his conversation with the Head of Department, a professor of psychology, he had come to the conclusion that I might be manic depressive or merely an unusual person. He recommended a battery of invasive tests by his medical colleagues, to set some baseline data in case I appeared to decline and a return visit in six months. As I have always viewed talking to people as completely different from letting them stick things in my body, I declined his offer, which would also have been paid for on workers' compensation. This was the first time I have ever visited a psychiatrist. I did so out of curiosity and as Sydney Uni. was paying. The experience gave me chilling insight into how people in more difficult situations than I might find themselves the victims of self-fulfilling prophecies by 'experts' pursuing their business.

In response to your letter, however, I fear I can only repeat my original claim that:

The SEEF questionnaire is primarily an evaluation of disability, not an evaluation of the social, economic and environmental determinants of wellbeing, as is claimed.

You should view the National Health and Medical Research Council video entitled 'The Best Laid Plans' (shelved at 362.1) as you still appear not to understand why this is so. You state that your study will help you look at things that contribute to the development of ill health among older populations. You already have the 45 and Up study and already know what generally contributes to the development of ill health. It is poor diet, lack of exercise, smoking, alcohol, unemployment, chronic work related disabilities, falls and depression, if memory serves me correctly. I still fail to see what purpose your research will serve or what the terms 'social, economic and environmental' mean to you. It is not as if you can link the research to any disabled individuals, in order to help them adjust.

When I pointed out that the category of 'Reading' was missing from your catalogue of sedentary activities in Question 15, you stated it would be addressed later. In this context please consider the attached related advice I have provided to the Minister for Innovation, Industry, Science and Research's Book Industry Strategy Group on the Treatment of

Books and New Digital Platforms. It demonstrates how all goods, services and their supply chains are ideally conceptualised in related consumer and other communities to understand how many regional environments may be improved together from current and future environmental and social perspectives, as well as financial ones.

While I accept your point that self-rated health is a powerful predictor of subsequently becoming ill, I am concerned that more researchers than ever now appear to present as scientists rather than social scientists on the basis of giving out questionnaires. I think this leads to more authoritarian, wrongly blinkered perspectives and to more victims. For example, the term 'behavioural scientist' appears to suggest that such a person is different from a social scientist in some way in spite of the fact that behaviour, like history, is socially constructed. In Britain, on the other hand, the Wellcome medical display in the British Museum of Science superficially appears to conceive of psychology as 'a way of assisting the telling of stories about the self'. This seems a more accurate and less dominating approach to me, unless the psychologist is dealing directly with the organ of the brain, not the socially constructed mind and its expression in language or writing.

You say you 'would have loved to address in more detail' many of the issues I have raised but 'it was not possible within the constraints of the current project'. You also apologize for the lack of clarity in your questions and state you piloted them on several hundred 45 and Up participants last year. You should ask the Australian Bureau of Statistics (ABS) for help with questions. I worked with them closely when employed in the Department of Industrial Relations and in WorkCover. Closer contact would have ensured you avoided key mistakes, such as those related to indications of income, work, housing and tax status in questions 60, 61, and 62. When I worked in the public service I found the ABS advice enormously helpful as they constantly asked the questions 'What exactly do you want to find out and why?' They well understood that every question needs a good design to support a clear purpose, or taxpayers' money will be wasted.

You claim you appreciate my concerns about questions 68/69 and 74. Does that mean you agree with me? You will recall that 68 and 69 ask respectively about one's perceptions of friends and co-workers. I claimed that extremes may not be meaningfully reduced to an average tick. Question 74 asks 'Do you agree that most people in your neighbourhood can be trusted'? I claimed this is a foolish question because the immediate response is to ask 'Trusted to do what?' You state these were not questions you developed, but 'are established scales that reliably assess elements of social support and neighbourhood social capital'. Let me remind you that many global rating agencies were also supposed to be giving reliable indications of the economic health of major institutions until the global financial crisis showed they were enmeshed in tissues of lies. My view is that the 'reliable' assessments you refer to may often be similarly based.

I returned my completed SEEF questionnaire and in replying to you I now note that no questionnaire is on your website. This is unacceptable as it means that only those who actually receive the questionnaire will know what is in it. In the eleven years I spent in the Faculty of Health Sciences I often had to ask what specific research questions had been asked to achieve a supposed result. One should not expect people to trust in figures,

in the absence of all knowledge about the questions which supposedly underpin these computations and any related discussion of their supposed meaning. I have often made this point to no avail in regard to research presented in the Faculty of Health Sciences.

You state that to have questions 68/69 and 74 in an epidemiological study is 'quite innovative' and that if they show relationships with ill-health, then social supportive strategies, not medical solutions, may be needed for preventive health among older Australians. How do you envisage this working? To avoid wasting time and money there must be clarification of many related issues in the health areas in which you and many others work. For example, you state there are far fewer 'social epidemiology studies' than 'biomedical ones'. Can you define your key terms? I do not clearly grasp their respective meanings, aims and relationships to health promotion and risk management.

In spite of a Phd and publishing four books with international publishers in the ten years I worked in the Department of Industrial Relations and the WorkCover Authority, where I also applied the basic principles of risk management required by legislation, no research I designed when I later worked at Sydney University was funded. Since I wanted to teach the key principles of risk management to as many students as possible and also regard the constant undertaking of research as a comparative waste of time in situations where the answers to many problems are often obvious but politically unacceptable, this did not worry me much. However, we are all keenly aware that promotion depends on research which also provides the opportunity to pursue it further and to control the work of others.

While the NHMRC video, 'The Best Laid Plans' appears to have a view of health promotion consistent with the World Health Organization (WHO) Declaration of Alma Ata, many of those working in the field appear to be off on bizarre frolics of their own, which should be unacceptable to government. For example, the Australian text book 'Understanding Health, A Determinants Approach' edited by Keleher and Murphy and published by Oxford University Press (2004) informs one that the WHO and Australian government approved definition of health as 'a state of complete physical, mental and social wellbeing':

> 'confuses the actual state of health with what it is that determines health. It is a definition that masks the determinants by making the state of health itself the object of measurement, rather than focusing on the determinants as an object of measurement. (p, 99.)'

If academics like Keleher, Murphy and those who wrote with them are encouraging mass student and health professional rejection of the WHO and Australian government supported definitions of health, this is a big concern in regard to health promotion from any Australian government, industry and related community perspectives which ideally also seek to develop regional partnerships to improve it. Where do you stand on this issue? (I hesitate to call it a debate, as those working in related areas at Sydney University, with the exception of your current reply, appear to refuse to engage in any.)

Keleher and Murphy informed the reader (p. 10) that:

> ‘Determinants of health are often divided into distal and proximal determinants. A proximal determinant of health is one that is proximate or near to the change in health status. By ‘near’ one can mean near in either time or distance, but generally it refers to any determinant of health that is readily and directly associated with the change in health status. Proximal determinants are also referred to as downstream factors. In contrast, a distal determinant of health is one that is distant either in time or place from the change in health status. The association between the change in health status and the determinant may be indirect or hard to see because of other intervening events and locations. Distal determinants of health are also referred to as upstream factors.’

I have no idea what they are talking about and I have read their book. However, in stating their key concept ‘near’ may refer either to time or distance, they appear to conflate the historical and cultural contexts of any problem or related activity and so reduce the importance of both for gaining understanding. This is highly problematic if many situations can only be effectively understood as constructs of particular historical and cultural circumstances. The WHO appears to claim that this is the case and I agree.

Discussion which follows on the upstream, midstream and downstream factors (ie. ‘the determinants of health’) is confused and confusing. This is not a trivial matter to anyone who hates the narrow, ignorant, authoritarian, personality. Keleher and Murphy say: (2004, p. 5)

- Downstream factors are those at micro level including treatment systems, disease management and investment in clinical research
- Midstream factors are those at the intermediate level including lifestyle, behavioural and individual prevention programs
- Upstream factors are at the macro level including government policies, global trade agreements and investment in population health research

I fail to see what makes investment in clinical research a downstream factor and investment in population health research an upstream factor. This is not explained. The patient or client also seems absent from the analysis. Their ‘health status’ appears to stand for them instead. On page 110 one is told that governments are typically more concerned with downstream and midstream approaches than with upstream approaches and that genuinely collaborative, multidisciplinary downstream, midstream and upstream actions are necessary. I have no idea what these are expected to look like, but I bet health professionals ideally see themselves as driving in all directions. (They are far from fit.)

The above is not the ideal regional, holistic, community based and client centred approach to health promotion which was outlined in the Declaration of Alma-Ata and ideally adopted by Australian governments. Where does your research stand in relation to it?

As I pointed out previously, in the Declaration of Alma-Ata, primary health care ‘involves, in addition to the health sector, all related sectors and aspects of community development, in particular agriculture, animal husbandry, food, industry, education,

housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors'. The ideal approach sees all work and other activity as located in communities and natural environments from which risks and many related challenges arise. The identification and control of the major risks to health are ideally attempted in related regional contexts and comparative outcomes of projects to do this are evaluated.

As I have also pointed out many times to researchers apparently like those in your team, in Australia, peoples' apparent 'choice', as indicated by their tick on a questionnaire, may often be largely determined by the pre-existing provision or absence of certain private or government services. This is not the US where choice ideally drives the private sector establishment of services in an otherwise unplanned fashion, so I fail to see why the US research leadership is followed so assiduously in Australia. Compared with most other OECD countries, the US now has poorer health, inadequate and more expensive health care, obscenely wide income differentials, lower minimum wages, fewer paid holidays, higher education costs, more unstable employment, lost savings, huge government and personal debts, major homelessness, the highest murder rate in the OECD and many deaths and injuries from constant war. They are also getting fatter. I have argued repeatedly that Australian researchers are led in very poor directions by their colleagues in the US. Many of those working at Sydney University are certainly no exception.

I hope the above clarifies my continuing concerns about SEEF direction and let me again thank you for your letter. Fortunately I am not at the stage where lack of intellectual response to my concerns has made me feel that I may become invisible unless I act up.

Yours truly
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COMPLAINT ABOUT THE SYDNEY UNIVERSITY SOCIAL, ECONOMIC AND ENVIRONMENTAL FACTORS QUESTIONNAIRE: (THE SEEF PROJECT)

The SEEF questionnaire is primarily an evaluation of disability, not an evaluation of the social, economic and environmental determinants of wellbeing, as is claimed.

What is its purpose in the minds of those who devised this questionnaire? Is its true purpose to pursue calculation of costs and benefits of treatment in medical settings? If so, the fact that this aim was not clearly pointed out to participants is highly unethical and the Ethics Committee and related researchers should all be shot.

The Social, Economic and Environmental Factors (SEEF) questionnaire from Sydney University claims to look 'at which social, economic and environmental factors play a key role in the health and wellbeing in the 45 and Up Study'. This claim is not true. The questionnaire is mainly a self-evaluation of one's level of physical and mental disability or distress. When I received the SEEF questionnaire I puzzled over what the researchers thought they could possibly do with the results. I would be grateful for an answer. Why are you doing this research? How will it 'help people live healthy and fulfilling lives for as long as possible'?

The SEEF questionnaire reminds me of the problems addressed in a National Health and Medical Research Council video entitled 'The Best Laid Plans' (shelved at 362.1) which I used to show to my first year students in the Faculty of Health Sciences in order to help them understand the requirements of the World Health Organization (WHO) Declaration of Alma-Ata on health promotion and how to consultatively initiate related community planning and development actions, in the face of much self-interested opposition. I heartily recommend this video to all people trying to understand governance.

The NHMRC video deals with how government bureaucrats and professionals may impose closed questionnaires on communities in a process which ignores their real wants and needs in order to construct a building which houses a bunch of health professionals instead. All the controlling politicians and workers are then happy. The building industry can construct the building and the health professionals can fill it full of their own in order to continue with their apparently central mission of inviting us to become more like narrowly self-interested invalids with a right to be dependant. The preferable alternative is to assist people to gain work and related training and education to become more independent, responsible and contributing adults, who are capable of work and enjoyment without depending on sitting at the feet of expensive, key professionals who may be far away. The national broadband network is very important in assisting this development.

In the WHO Declaration of Alma-Ata, primary health care 'involves, in addition to the health sector, all related sectors and aspects of community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors'. The related WHO approach to healthy action sees all work, play and related

living as located in regional communities and environments from which risks and many related environmental challenges arise and are accordingly prioritized for remedial action. The identification and control of the major risks to health are ideally conducted in this regional context. The approach to handling environmental risk and social (health) risk are ideally treated in coordinated ways - in the Murray Darling Basin, for example.

More specific comments about the SEEF questionnaire on disability (The few questions which are not on disability are often very badly designed).

Question 4 asks have I ever been a smoker and Q.7 allows me to indicate whether I smoke pipes and cigars. I smoke less than one very small marihuana joint per day. Does that make me a regular smoker? I have assumed your questionnaire is about tobacco. Don't you care about the health effects of marihuana or doctor prescribed drugs?

Question 8 asks me about alcoholic drinks. I indicated that I have 14 drinks per week. I have purposely bought very small wine glasses. If I had two drinks per evening in some of the wine glasses I see in the shops I would have consumed at least twice as much wine as I currently do. (A bottle lasts me 3 days and a cask lasts more than a week.)

It is noteworthy that the questionnaire does not ask about my consumption of legal medications prescribed by doctors. I guess this is because this question is seen by the public health specialists who devised this questionnaire as being outside the safety of their professional silo. I guess they would hate to hear the answers. I take no medications prescribed by a doctor and have never done so other than fleetingly. I get the impression that people who think taking medications will fix their problems may also think those medicines have no unintended consequences. Why don't you ask what legal medications we take? Don't you think legal drugs are ever risky to health?

Question 15 asks how many hours per day I spend sleeping, watching television and using a computer. Earlier questions asked about physical exercise. However, nowhere is reading mentioned. I guess that reading newspapers, books and magazines is probably a more important way of spending time than computer use is for most people around my age. The fact it was left out in Q.15 also made answering that question confusing to me. What exactly do you want to know and why?

Question 22 asks me to describe my family home but does not have a 'town house' option. This is a pity because town houses are good for many reasons such as the fact that they are self-contained like a house while also allowing the benefits of strata title. Anybody concerned about creating good housing should have been aware of this option.

Question 23 asks: 'Do you currently own (or are paying off mortgage for) any other property that you do not live in'? I cannot give the correct answer to this question, which is an important one because it is about my level of economic support – which may explain more than anything else about my level of well being. I lent my daughter money to purchase a flat. Her name is on the title deed but she is repaying me a loan of around $300,000 at $250 per week which is an income supplement for me.

Question 25 asks me about feeling too hot or cold. This is bizarre. Don't you care whether I find the place too noisy or too dirty or that it has too many or too few trees around it, or has bad neighbours? These issues are much more likely to drive city people nuts, in my experience. Why the later obsession (Q.27) with my source of drinking water? If I don't trust tap water that may say more about me than it does about the tap.

In general, do you intend to treat perception as reality? If so you may be playing into an increasingly irrational social hysteria driven by many women and their health practitioners, perhaps to the detriment of all people with broader and more rational views of comparative risk. Men are less likely to occupy the highly risk averse end of the social spectrum than women, as is demonstrated by a review of their work and play habits. I guess that the willing acceptance of risk is the primary difference between male and female social roles. However, if female risk aversion is followed to its logical conclusion by women becoming the handmaidens of lawyers and medical specialists, while also following in their professional attitudinal footsteps, then many social treatments, rewards and punishments will become even more distorted, irrational and unfair as time increases.

Question 30 asks me about my memory. I have an amazing recall for songs and could sing the whole score of 'The sound of music', 'West Side Story' or many other Broadway shows or other songs with very little prompting. However, if you tell me your name, I will forget it two seconds later. How would you want me to fill in your questionnaire? (I guess one recalls what one loved or needs to recall and ignores the rest as one ages, especially if one is invited or seeks to depend upon others.)

Question 30 also asks me about my teeth and gums. Until a couple of years ago I thought my teeth and gums were fine. I have now lost a tooth so had a false one made on one side and have had a wobbly tooth connected to its neighbour on the other. If you can tell me if this is poor or something else for a 63 year old Australian I'd be grateful. (I have searched the internet for such comparative data to no avail). A more important issue, however, is how I should address my teeth in future – definitely without a peridontist! (They do a roaring trade in nursing homes?)

Question 60 asks 'What is your usual yearly HOUSEHOLD income before tax, from all services'. I am a self funded retiree so pay no tax. My income before and after tax is between $40,000 - $49,000 which is also plenty for me to live on because I pay no tax and own my dwelling outright. (The same problem of ignoring a person's tax status occurs in Q.61. Why don't you inquire about after-tax income, which is what people have to live on, rather than pre tax income? What are you trying to find out?)

Question 62 asks 'What is your current work status?' I am a self-funded retiree so presumably should tick your box labeled (**completely retired/pensioner**). For planning and investment purposes as well as for your estimation of my income, and hence my related wellbeing, this box is misleading. To be a self funded retiree may be bliss. For example, one may fund one's personal mission without being called into the Dean's office every week to explain that if he acts on every complaint that every female moron

makes to him in secret about what I say or write, he will continue to do irreparable damage to the university and society. The most dangerous places in society are more likely to be frequented by men rather than women. The kind of academics currently being encouraged in Health Sciences are in turn encouraging their students to be too frightened to go or intervene anywhere men are working, swearing or doing any of the other naughty things men often like doing when they are together with their fellows or by themselves. Don't you care about anybody's sex life? Why does the questionnaire not address this?

Questions 68 and 69 ask respectively about one's perceptions of friends and co-workers. The problem for the individual answering such questions is that extremes cannot often be meaningfully reduced to an average, which is what the questionnaire demands of one. For example, if one had only two relatives and one's daughter was a paragon of joy and virtue, whereas one could cheerfully bash one's older sister's brains out, how should one sensibly fill in the section on how one feels about one's family members? Such people cannot be conflated to come up with a satisfying tick for your questionnaire. Many people are also engaged in adversarial relations where they have supporters who comfort them against those who have been cast as their enemies. This is not my case as I am too personally disengaged to care much about what others think of me. (Having spent a more socially connected youth I am now quite happy to be relieved of caring, other than in relation to my daughter, who nevertheless sensibly gets on with her own life, not mine.)

Question 74 asks 'Do you agree that most people in your neighbourhood can be trusted'? This is a foolish question because the immediate response is to ask 'Trusted to do what?' For example, if I leave the plate glass doors to my townhouse unlocked most people will not jump over my verandahs or back fence and enter the house. However, I have found that a sufficient number are so likely to do so that I am meticulous about locking doors and windows. Yours seems a strange question to me. What are you trying to find out?

Questions 77 and 78 ask respectively about one's past places of living and places of work. At the end of a long questionnaire I find these questions very confusing to fill in and wonder whether you will get much clear or useful information from most people. What were you hoping to find out and why?

Related discussion on the WHO and SEEF Project Perspectives

From the WHO perspective the SEEF Project appears to be part of the social problem rather than part of the social solution to poor health. The health problems people face appear often to result from poor diet, lack of exercise, smoking, unemployment, alcohol, accidents and work. Solutions for many common health problems are likely to be found in encouraging healthier food and drug consumption, more vigorous exercise, more paid work, and more fulfilling and supportive education and entertainment. Instead of this, many problems appear to have been deemed medical in order to control them. For example, as the cane is banished from schools, the teacher and psychologist may naturally respond by calling for a diagnosis of attention deficit hyperactivity disorder so as to pacify lots of boys who hate school and who are ruining it for everybody else.

(Given the difficult choice between the current discipline approaches I prefer the cane as being more honest and less disabling than delivery of legal drugs at taxpayer expense.)

To clarify my criticism of your questionnaire let me explain that last year I went to the small, historic and attractive town of Lake Cargelligo to investigate potential for a green building demonstration project on land that a friend in the construction industry had bought there. The lake had recovered after ten years of drought which had seen it gradually emptied and which had also impoverished the surrounding farming community and generated considerable business decline. Lake Cargelligo appeared to suffer from a lack of skilled building workers, which would make greener construction hard and expensive. However, it had other good services for a country town because there was a doctor, hospital, child care centre and a technical and further education centre as well as primary and secondary schools and a reasonable amount of public transport available to its inhabitants. There were lots of cheap empty businesses and fibro houses in the town, sporting lots of broken air conditioning systems.

On very superficial examination it seemed to me that if anyone was concerned about health promotion or any related community development in Lake Cargelligo, they would first have to work out how the town could produce goods and services that people could afford to buy and would want to use. Would the SEEF questionnaire help? I doubt it. The proposed construction of a new technical and further education building at Orange, where people will have to go if they want to learn green building techniques does not seem to help with the problem either. People need to be able to work and learn where they live and often cannot afford to leave their dependants in order to go to sit at the feet of teachers at some big new building far away from where their communities are located.

On the other hand, I can see how the SEEF project could lead to the consumption of more legal drugs to medicate various forms of actual or supposed disability. The culture of the administration of legal drugs, of which the SEEF questionnaire appears to be a product, is predominantly inhabited by women acting to support the power of male specialists who are also academics. It is part of the same social process that denies or denigrates the skills and demands upon many of Australia's most productive men who work in trades or in related forms of production more skilled than much of the work which goes under the name of health or social care. The provision of good care, like all good work, is often a result of caring states of mind and practical experience, rather than the result of the accumulation of specified professional knowledge and related certificates. (This is not to deny the knowledge or skills of nurses, physiotherapists, doctors and others which are acquired in practicing institutions, or to deny the key place of certificates of competence.)

If I lived at Lake Cargelligo, I guess I might first suggest a work project to beautify and build a pathway around the whole lake because this would be inviting to people like me as well as beautifying the town centre and creating basic work, exercise and training opportunities. As the takeaway shop does a roaring trade I might suggest exploring the potential for a community garden which grew salad and other foods for the shop as well as for delivery into an ordering community. Mung beans, green and red lentils and other hippie foods can also improve diets if they are attractively prepared so that more

traditional Australians are willing to eat them. I also guessed that a concrete skateboarding shell and cheap skateboard hire service might be welcomed by teenagers. Obviously, however, the people in Lake Cargelligo are likely to have a much better idea of what they want and need for healthy development than I have. I merely point out a better approach to ascertaining the social, economic and environmental determinants of health, which may be more appropriately conceptualized as wellbeing in many cases.

My guess is that the SEEF questionnaire was designed partly to assist investigation of the calculation of the costs and benefits of treatment in medical settings. According to Professor Stephen Leeder, writing in the Sydney Morning Herald (23-24.10.10, News Review p. 12) the quality-adjusted life year (QALY) and the disability-adjusted life year (DALY) serve to compare diseases and treatments with a view to stopping the wastage of treatments on people who, for whatever reason, will get no benefit. Those of us participating in this questionnaire appear to me to be likely to be helping health professionals to make decisions over life and death matters we cannot control ourselves.

For example, I demand the right to kill myself easily and conveniently when I eventually tire of life in order to donate my body for its most useful purposes, rather than continuing to be an expensive drain on taxpayers or my daughter, while living for years in a helpless state which is the total antithesis of dignified to me. Since the law denies me any control over the circumstances of my own death it is highly unethical if any health professionals are now developing their self-interested ideas about such matters through delivering questionnaires which do not make their purposes clear to respondents. This is disgusting.

Yours truly
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