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Against the Very Idea of the Politicization of Public Health Policy

Daniel S. Goldberg, JD, PhD

I criticize the concern over the politicization of public health policy as a justification for preferring a narrow to a broad model of public health.

My critique proceeds along 2 lines. First, the fact that administrative structures and actors are primary sources of public health policy demonstrates its inescapably political and politicized nature. Second, historical evidence shows that public health in Great Britain and the United States has from its very inception been political and politicized.

I conclude by noting legitimate ethical concerns regarding the political nature of public health policy and argue that open deliberation in a democratic social order is best served by acknowledging the constraints of the inescapably politicized process of public health policymaking. (*Am J Public Health.* 2012;102:44–49. doi:10.2105/AJPH.2011.300325)

THERE EXIST COMPELLING ethical justifications for a broad model of public health, one tied to the best evidence regarding the prime determinants of health, illness, and inequities in human societies.[1] Such a model suggests the insufficiency of a narrow model of public health, one

that eschews intensive social interventions in favor of a restricted scope that focuses public health resources on what Fairchild et al.[2] have termed the "basic 6":

1. collecting vital statistics;
2. controlling communicable disease;
3. sanitation;
4. laboratory services;
5. maternal, infant, and child health services; and
6. health education

There also exist numerous significant arguments in opposition to a broad model of public health. My goal is to critique 1 common argument issued in favor of a narrow model and to suggest that although there are numerous good reasons for preferring a narrow to a broad model of public health, the particular argument considered here is not one of them. Specifically, the argument of concern suggests that a narrow model of public health is preferable to a broad model because the latter carries significant risks of politicizing public health policy.

CONCERNS OVER THE POLITICIZATION OF PUBLIC HEALTH POLICY

Contributors to the broad versus narrow debate have repeatedly voiced concern over the politicization of public health policy. As far back as 1991, one of the topics in the curriculum of the Public Health Leadership Institute was the "politicization of public health."[3] In the Milbank Fund's 1994 report *Leadership in Public Health*, Molly Joel Coye refers to the "painful subject" of "the politicization of priorities and funding," which renders it difficult for "agency administrators to make sensible, outcome-driven decisions about resource allocation and program priorities."[4]

In his seminal analysis of public health law, Lawrence Gostin observes that were public health policymakers to focus the lion's share of their energies on the amelioration of social and economic conditions (arguably the core of the broad model), they would risk overreaching:

> [P]ublic health gains credibility from its adherence to science, and if it strays too far into political advocacy, it may lose the appearance of objectivity. . . . [If] public health conceives of itself too expansively, it will be accused of overreaching and invading a sphere reserved for politics, not science.[5(p41)]

Gostin and James Hodge similarly lament efforts at politicization of public health law in Alaska's recent efforts to reform and update its public health laws.[6] Mark Rothstein, who has consistently endorsed a narrow model of public health, agrees with Gostin that "by becoming involved with economic redistribution and social restructuring, the field [of public health] becomes highly politicized."[7(p145)]

In 2005, Claude Earl Fox lamented that in 32 years of public health practice, he has

> watched virtually every level of public health become more politicized. Whether it's federal officials or health officers at the state level, they are all appointed now by governors, mayors, or some political entity.[8(pp19-20)]

Although Fox is no doubt focusing on the identity of the appointers here, he seems concerned precisely because the figures appointing public health leaders participate overtly in the political sphere. Finally, in the popular media the *Wall Street Journal* published a 1996 editorial by Sally Satel decrying the politicization of public health,[9] and James Bennett and Thomas DiLorenzo authored a 2000 book criticizing what they perceive as the "transformation of public health from pathology to politics."[10(p135)]

MEANING OF THE CONCERNS

These examples constitute only a small portion of the lay and scholarly discourse that cites concern about the politicization of public health. However, the literature contains virtually no precise definition of politicization, a term that may serve numerous different functions depending on the purpose, context, and identity of the speakers. Nevertheless, the apparent lack of a definition of politicization does not preclude analysis because there are some uses of the term that, although insufficient to stand as a strict definition, seem common to many of the concerns. One such use is the idea that the science of public health should govern its policies and priorities and that such science is ultimately descriptive rather than normative. As Kraemer and Gostin put it, "Science is, and can only be, descriptive and explanatory. . . . [T]he sciences cannot be normative."[11(p666)] Similarly, although Rothstein agrees that politicization in the context of public health is difficult to define, he worries that

> the scientific objectivity and credibility on which public health relies is compromised by using outcome-oriented scientific analyses to achieve political ends. (M. A. Rothstein, JD, e-mail communication, May 2011)

Thus, to its detractors, politicized public health policy strays too far from sober assessment of scientific facts and runs the risk of constituting naked political advocacy.[5–7,9–11] Many critics of politicization therefore perceive as the central problem excessive entanglement of scientific facts with value positions regarding what ends a just social order ought to pursue.

Moreover, concerns over politicization often serve as a prudential warning that public health policymakers should avoid matters of vigorous political controversy. Gostin and Rothstein both suggest that if public health policies attempt to ameliorate social and economic problems, they may lose the credibility that is critical to the profession's influence in priority setting and policy crafting. Rothstein warns that in a broad model of public health, one presumably grounded in political action and advocacy,

> the urgency of public health will become diluted, and the public will have an increasingly difficult time in distinguishing public health from public relations.[7(p145)]

There is merit to this pragmatic concern, but these anxieties have specific substantive meaning that concerns over politicization obfuscate. The response here is that concerns over politicizing public health policy essentially rest on truisms that do little to advance

the debate regarding broad versus narrow models of public health. Finally, inasmuch as rhetoric of politicization obstructs critical debate on the appropriate goals and priorities of public health, it may carry significant ethical implications. Accordingly, even legitimate prudential concerns do not justify anxiety over politicization.

CONCERNS OVER POLITICIZATION REST ON A TRUISM

I offer 2 lines of analysis to support my response. The first is that whether drawn from common law, statutes, or regulations, US public health law and policy are inescapably political and politicized. The second level of analysis specifically addresses the history of public health in the Western world and suggests that public health practice and policy have from their very inception been overtly political in virtually every conceivable sense of the term.

Political Nature of Public Health Law and Policy

Although public health law and policy are not identical, they are linked at a deep level. Gostin defines the former as

> the study of the legal powers and duties of the state, in collaboration with its partners . . . to ensure the conditions for people to be healthy . . . and of the limitations on the power of the state to constrain for the common good the autonomy, privacy, liberty, proprietary, and other legally protected interests of individuals.[5(p4)]

This definition captures one element common to both broad and narrow models of public health: its identification of state actors as primary agents of public health law. Such actors operate through all 3 branches of government, and each level is politicized. Thus, Eleanor Kinney observes that

> in any matter in which the government takes the lead, politics are implicated, thus inevitably introducing considerations other than pure science into the resolution of questions of scientific policy.[12(p212)]

Yet, however important cases and statutes are, the significance of the regulatory apparatus for public health law cannot be overstated. Edward Richards even goes so far as to argue that public health law literally is administrative law.[13] Organizations that constitute the modern administrative state include formal regulatory bodies such as the Food and Drug Administration and state boards of health, but they also include so-called quasilegal bodies, which are often private actors that have a significant influence on public health law and policy (e.g., the Joint Commission).

If legal and quasilegal bodies charged with regulating public health law and policy are significant if not exclusive sources of such law and policy, some important implications follow for evaluating the concern over the politicization of public health. This is because it is indisputable that regulatory regimes are deeply and fundamentally enmeshed with political processes, concerns, and pathways.[14–16] As Kenneth Meier observes,

> [r]egulatory policy is a result of complex interaction of industry, consumers, regulators, political elites, and the environment in which they operate.[17(pxv)]

Given this interaction, suggesting that any corpus of regulatory law or policy is apolitical defies credulity.

If American regulatory processes are fundamentally political in nature, the semantics of the claim that public health policy ought not be politicized are puzzling. How can an ineliminably political process avoid politicization? As Leigh Turner explains in the context of science policy,

> [i]n democratic social orders, the formation of science policy is an ethical and political process . . . . Policy formation . . . include[s] contestable judgments, the search for credibility and legitimation, the marshalling and critique of evidence, and often rhetorical appeals to the public good.[18(p35-36)]

Empirical confirmation of Turner's account is evident in the history of public health in the Western world (especially in Great Britain and the United States), which demonstrates a tight connection between public health and politics throughout the 19th century.

The History of Politics in Public Health Policy

In the 19th century, as in the 20th century and now, larger political disputes shaped the policies and priorities of public health movements. In Great Britain, whereas figures like Engels and Scottish public health reformer W. P. Alison urged collective social action to ameliorate the devastating social and economic conditions of the 19th-century urban poor, the Chadwickians narrowed the scope of the public health platform considerably by focusing simply on the poisons thought to inhabit filth (for which sanitation was the obvious policy remedy). As Christopher Hamlin has shown, Edwin Chadwick was primarily motivated by a desire to preserve existing social and class hierarchies in the form of the 1834 New Poor Law, not to overturn them or flatten the social gradient of health.[19] Similarly, Simon Szreter has demonstrated that in the mid- to late-Victorian era, when free market ideals and classical economic liberalism dominated civic discourse, the political climate precluded any intensive efforts on the part of the central government to invest extensive capital in sanitary and public health improvements.[20] That is, relative to other priorities the British polity simply did not value public health interventions enough to take collective action, and Szreter emphasizes that the lack of action was for want of neither sufficient understanding of the causes of disease nor technical capacity to intervene.[20]

Not coincidentally, Szreter argues, during the several decades in the mid-19th century when organized and collective public health interventions were politically untenable, demographic historians have documented shocking mortality rates in British cities concomitant with the disruptions posed by urbanization and industrialization.[20] Szreter explains that subsequent demographic changes in the increasing numbers of working urban poor combined with enfranchisement led to the rise of local government structures whose augmented political power

was fundamental to the public health improvements of the ensuing decades.[20] The key point is that the British polity's earlier eschewal of intensive public health policy reforms and interventions was every bit as political and value driven as were the subsequent and intensive local and municipal public health efforts.

Politics and political concerns therefore deeply shaped and influenced the course of public health policy in 19th-century Britain, and there is no reason specific to the history of public health in the United States to think that it escapes the tight linkage between political variables and public health policies and priorities. The same class-based and moralist dynamic that animated leading figures in the British public health movement is evident in American reformers. John Duffy observes that for Lemuel Shattuck

> and most of his contemporaries, the basic problem with the poor lay. . . in their lack of moral fiber; hence a function of government was to teach them the laws of nature and to raise their moral level.[21(p99)]

Shattuck's focus on the dearth of moral fiber among the indigent was one reason his ideas were readily accepted by US physicians, who had "never doubted" its lack.[21] Similarly, although second-generation American public health advocates perceived germs as a common enemy that social groups and classes ought to unite against, public health programs were saturated with ethnic, racial, and class prejudices.[22–24] Although this saturation shows that political underpinnings of public health policies are not necessarily just, it also demonstrates the irreducibly political nature, for better or sometimes for worse, of those policies and priorities.

But the political nature of public health policy goes well beyond class and ideological influences to the very understandings of disease itself.[16] For example, Margaret Humphreys documents how 19th-century communities in the American South often preferred the miasmatic theory to the contagionist model of disease because the latter account would imply the corresponding policy of quarantine, which had significant political and commercial consequences.[25] Charles Rosenberg observes the same phenomenon as to cholera epidemics in both America and Europe during the 19th century.[26,27] Thus, political economies strongly influenced both the causal attribution of disease and the attendant policies enacted to prevent and curb epidemics when they occurred. The point is that political entanglements colored the acquisition and interpretation of scientific facts at a deep level, as well as their translation into public health policy.

In addition, priority setting in public health research is also political and politicized. David Oshinsky's history of polio in 20th-century America explores the political pressures that resulted in enormous national expenditures on polio research.[28] As terrible an illness as polio is, it is telling that according to Oshinsky, in 1954 the National Foundation for Infantile Paralysis raised $66.4 million to support polio research, which had a prevalence of 100 000 cases. By contrast, combining the amounts raised by the American Cancer Society, the American Heart Association, the National Association for Mental Health, and the Arthritis Foundation yields a sum of $37.3 million, although the combined prevalence of cancer, cardiovascular disease, mental illness, and arthritis in 1954 was almost 32 million cases.[28] Of course, the enormous gap between allocation of research dollars and disease burden is as much a problem now as then,[29] but Oshinsky's point is precisely that powerful political factors—including the immense political shadow of Franklin Roosevelt himself—drove the intense national interest in funding and researching polio although a variety of other chronic illnesses was undoubtedly more prevalent and more incident across the whole population (and, hence, arguably of higher priority).

Historical analysis of changing models of public health also shows the significance of politics and political concerns to public health law and policy. One reason the survey of this connection by Fairchild et al. is so important is that it shows how the 20th- and 21st-century decisions to avoid the kinds of interventionalist approaches that in large part characterized 19th-century public health activities is itself political in nature.[2] These decisions were and remain driven by a host of diverse political concerns of exactly the kind that Turner notes is a feature of pluralistic, democratic societies.[2,18] As Fairchild et al. suggest, individualist models tend to dominate American practices of public health, health education, and health promotion.[2] Such models are discursive products of the highly individualist political culture in the United States,[30–32] just as more collectivist models of public health practice and policy in, for example, Sweden and Japan are inextricably tied to the peculiar culture, values, and history of the respective polities in those nations. Thus, the argument that public health practices should avoid calls for broad-based social reform because such activities run the risk of politicization is, ironically, a political argument to the core.

ETHICAL IMPLICATIONS OF THE POLITICIZATION ARGUMENT

This discussion is not merely a matter of terminology; there are significant ethical implications flowing from the inherently political nature of regulation and policy. One such consequence can be termed the "unbearable oughtness of public health policy," which refers to the basic fact that assessing, implementing, and enforcing health policies fundamentally requires normative decisions. Particularly regarding public health policy analysis in the United States, a strangely prominent view seems to be that measuring, for example, costs and benefits of a particular public health intervention can, in Turner's words, "automatically dictate social policies."[18] This inference is erroneous in no small part because it qualifies as a rank instance of the naturalistic fallacy; the mere fact that a set of arrangements for the provision of public health goods or services satisfies any given cost–benefit ratio does not in and of itself license any particular conclusion

about what a just social order ought or ought not do. As Quanstrum and Hayward recently put it,

> Scientific evidence can only help us describe the continuum of benefit versus harm. The assessment of whether the benefit is great enough to warrant the risk of harm—i.e., the decision of where the threshold for intervention should lie—is necessarily a value judgment.[33(p1077)]

Such a judgment must be resolved politically, if it is to be resolved at all.

Therefore, the major premise underlying the argument that broad models of public health should be disfavored because they run the risk of politicization reflects a truism that does not advance the important debate over the optimal model of public health. The premise in question is trivially true in the sense that public health policy is saturated with politics and political concerns; hence, the notion that any model of public health policy can to any significant extent avoid politics and political concerns is inconceivable. Furthermore, because public health policy is inexorably political, the ethical dictum that "ought" implies "can" vitiates the claim that public health policymakers ought to avoid political engagements. When policymakers cannot avoid politics in setting public health priorities, there is little ethical justification for thinking that they ought to do so. Politicization is the nature of the beast and is an inescapable component of translating public health theory into policy.

Before concluding, it is worth pointing out that some of the prudential concerns raised under the mantle of politicization are reasonable and ethically significant. Examples include worries over willful ignorance of relevant evidence, removal or obstruction of qualified persons from policymaking bodies, failure to include diverse voices, and suppression of dissent.[18] All of these are important ethical concerns to public health policymaking, and the extent of their presence in any particular exercise could undermine confidence in the resultant policies. But these concerns are detrimental features of the political process. They are results of the ineluctably political nature of public health policy rather than reasons for denying it. Honest interlocutors should scrutinize policymaking efforts and practices carefully for signs of the deleterious characteristics that attend any democratic political process and should relentlessly criticize such deficiencies. However, to criticize errors and foibles of the political process is not equivalent to suggesting that an inexorably political process must somehow be made apolitical. Thus, the legitimacy of the prudential concerns does not somehow make fears over politicization coherent.

The question at issue in assessing the merits of a broad versus a narrow model of public health is whether broad-based social and political reform should be a mainstay of public health policy. Advocates of a broad model claim precisely that active and dedicated, if not radical, social and political measures are exactly what are required if population health is to be sustained and improved and health inequities to be compressed or eliminated. Consequently, asserting that such reforms ought not be regarded as within the ambit of public health policy because they would result in excessive politicization of public health assumes the conclusion. For many proponents of a broad model, excessive politicization, or at least vigorous political action, is in fact the goal. Thus, without specifying what the precise concern is regarding the political action sought—which is exactly what Turner indicates is required to make sense of the anxiety over politicization of bioethics or science policy[18]—the argument seems either trivially true, and hence inconsequential, or else tautological.

Ultimately, the political nature of public health policy grounds Virchow's dictum that social medicine is nothing but politics on a large scale,[34] even if one ultimately rejects the broad interventionist model of public health that Virchow's position implicitly supports. Politics cannot be separated from public health policy any more than values can be excised from human endeavors. There are myriad reasons for preferring a narrow to a broad model of public health. But vague concerns over politicization are not among them and may obscure the open exchange of values and positions that ought to characterize deliberation in a just social order.[18,35] ■

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Wellness Incentives, Equity, and the 5 Groups Problem

Harald Schmidt, MA

Wellness incentives are an increasingly popular means of encouraging participation in prevention programs, but they may not benefit all groups equally.

To assist those planning, conducting, and evaluating incentive programs, I describe the impact of incentives on 5 groups: the ''lucky ones,'' the ''yes-I-can'' group, the ''I'll-do-it-tomorrow'' group, the ''unlucky ones,'' and the ''leave-me-alone'' group. The 5 groups problem concerns the question of when disparities in the capacity to use incentive programs constitute unfairness and how policymakers ought to respond.

I outline 4 policy options: to continue to offer incentives universally, to offer them universally but with modifications, to offer targeted rather than universal programs, and to abandon incentive programs altogether. (*Am J Public Health.* 2012;102:49–54. doi:10.2105/AJPH.2011.300348)

INCENTIVES AIMED AT individuals increasingly play a role in the organization of health care systems.[1,2] Wellness incentives are intended to encourage uptake of prevention and health promotion programs. A recent survey also found that 56% of large US employers see wellness programs as 1 of the top 3 strategies for curbing cost.[3] Savings may result, for example, from reduced health care expenditure owing to a healthier workforce or from incentives structured in a way that shifts health care cost from employers to employees. The goals of health promotion and cost containment may come into conflict, and the fairness of wellness programs depends significantly on their implementation. Various ethical issues may arise, but a central concern is equity, because ideally, all who are offered incentive programs should enjoy equal opportunity to access them, especially when associated benefits are substantial.

Regulations issued by the US Departments of Labor, Treasury, and Health and Human Services in 2006 distinguish between 2 principal forms of incentives.[4] Process incentives may offer a premium discount or rebate for participating in, for example, an exercise, weight-loss, or smoking cessation program. Outcome incentives link monetary benefits to meeting certain risk factor targets, such as body mass index (BMI) or blood pressure thresholds. The regulations impose no cap on process incentive levels, but for