

Policy, politics and public health

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If public health is the field that diagnoses and strives to cure social ills, then understanding political causes and cures for health problems should be an intrinsic part of the field. In this article, we argue that there is no support for the simple and common, implicit model of politics in which scientific evidence plus political will produces healthy policies. Efforts to improve the translation of evidence into policy such as knowledge transfer work only under certain circumstances. These circumstances are frequently political, and to be understood through systematic inquiry into basic features of the political economy such as institutions, partisanship and the organization of labour markets.

Introduction

Politics is ubiquitous in public health, as befits a value-driven field engaged in the use of public power for the betterment of the human lot. That makes the enduring paucity of political science informed analysis and strategy in mainstream public health professional culture all the more puzzling.^{1–5} If public health is to society as doctors are to patients, then understanding politics and policy is no less critical to us than understanding a patient's needs and life should be to a doctor.

Nonetheless, many public health professionals consider engaging with the political system to be outside their area of expertise or mandate. It seems that the public health community limits itself to a 'technical' health expert advisory role for political decision-makers, preparing advice that might never be requested for reasons we do not understand. As Oliver notes, 'Science can identify solutions to pressing public health problems, but only politics can turn most of those solutions into reality.'⁶

Many academics reproduce and further strengthen political disengagement by publishing analyses of health issues and policies that neglect the characteristics of the political system. Numerous 'calls to action' exist in the literature, alongside calls for 'political will'. Still more articles identify problems but offer at most policy recommendations that go unheard beyond our paywalls, as if the politicians were to blame for not reading our journals and inferring what to do. This reveals a weak understanding of politics. Public health professionals would not, for example, call for 'individual will' as a solution to obesity. Nor should we call for political will as a solution to policy problems.

To take an urgent example, debates on climate change pit public health evidence and expertise against power. The US government has taken an anti-scientific stance, denying the well-established research on global warming. The rise of the populist radical right (Box 1) could have significant implications for vulnerable groups. Hatred towards migrants, and policies of exclusion rather than inclusion, are diametrically opposed to public health goals. Whether the populists gain power, and how, depends on the political context that makes them more or less powerful and their agendas more or less practical.⁸

Box 1 Populism and public health

- The 'populist radical right' is nativist (believing that there is an ethnically united people with a territory, aka nationalism or ethnocentrism), authoritarian (believing in the value of obeying and valuing authority) and populist (preferring the 'common sense' of a unified people to elite knowledge).⁷
- Populist politicians 'infect' regular party politics by showing the possible electoral rewards of adopting populist positions that might contradict evidence, norms or the law. This effect is visible in immigration policy in many countries, where mainstream parties adopted harsher policies as responses to populist radical right challengers.
- The populist radical right therefore challenges the checks and balances of the political democratic system and the protections that exist for minorities. Once in office, there is a risk of 'democratic backsliding' when 'elections happen but without a realistic chance of them leading to a transfer of power'.⁸
- Combined with a recent trend towards populist 'welfare chauvinism', populist policies could have very significant implications for unfair redistributive policies, unequal access to welfare benefits and increasing health inequalities.⁹
- Whether they will, and how, depends on the political context that makes them more or less powerful and their agendas more or less practical.⁸

The objective of this paper is to renew interest in a political analysis of health policymaking with the aims of (i) illustrating how the political economy, party politics, interest groups and institutions obstruct or facilitate particular public health policies and outcomes, and (ii) creating awareness of how public health interest representation should also allow politicians to claim credit and to avoid blame or inconclusiveness.

In the next section, we problematize the dominance of a simple model of evidence-based thinking and acting that is too common in

public health. We then provide a brief introduction to political-institutional analysis of health policy as an appetiser for developing a more sophisticated and user-friendly public health political science. We end with conclusions and implications for education, research and political organization and action.

How evidence-based medicine led us away from what matters

A perspective still dominant in the clinical as well as the public health world today assumes the primacy and purity of scientific evidence in informing health policy and health practice. This assumption has been very much driven by the broad—but biased—adoption of Cochrane's 'Effectiveness and Efficiency: Random Reflections on Health Services'.¹⁰ In this work, he demonstrated that many biomedical interventions were unfounded and sometimes even caused harm. A crude biomedical reinterpretation of his message emerged, in which the Cartesian 'randomized controlled trial (RCT)' became the 'Gold Standard' of evidence generation. Cochrane himself passionately argued for a humane and people-centred health—not care—system in which health professionals and patients jointly and holistically co-created health.

Put aside the difficulties of generating and using RCTs in biomedical research, let alone society. The idea of scientific knowledge generation and the production of immutable evidence was that scientific evidence would automatically and magically turn into solutions—be they appropriate and effective policies, or better practices. That idea has not been borne out by reality.

There are different ways of generating, using, transmitting and applying these different knowledges for the betterment of the world. The science around these relations and modalities, however, does not align very well with the Cartesian world view of which the RCT is the prime function. Authors such as Cairney and Oliver,¹¹ de Leeuw *et al.*,⁵ Bekker *et al.*¹² and Boswell (2008)¹³ clearly argue that 'knowledge' in its kaleidoscopic diversity is inherently political. It affects politics and is shaped by politics.

The clinical world, however, has struggled—and continues to struggle—with the need to develop simple, tools that would both explain and facilitate the movement of evidence into practice.^{4,11,13} An apparent solution was found in the idea of 'Knowledge Translation (KT)': '...a dynamic and iterative process that includes the synthesis, dissemination, exchange and ethically sound application of knowledge to improve health, provide more effective health services and products, and strengthen the health care system'.¹⁴ Greenhalgh and Wieringa¹⁵ argue that the uncritical and technocratic application of this idea has been doing more harm than good to health policy and practice. It may well work for the implementation of protocols for biomedical interventions, which has led to a clinical implementation science espoused by journals with similar names.¹⁶ But the complex and dynamic social world where so many actors try to shape policy and practice to serve their unique interests does not necessarily lend itself to the reductionist worldview.

The challenge to move knowledge and research into policy and practice can also be encountered in fields such as agriculture, engineering, mobility, social services and education. None of these, however, has adopted the KT rhetoric. In a systematic theoretical review (in which we selected conceptual approaches to this challenge that had been empirically validated) we found over 30 different notions, including 'intelligence co-creation' and 'joined-up knowledge utilisation'.¹⁷ Virtually all of them were at least implicitly, but often explicitly, political: they recognized how contentious 'knowledge' may be and how its consequences may or may not serve the interests of a (powerful) elite. The flip-side also was found: approaches to empower the voiceless to affect policy decisions affecting their lives.^{17,18}

Which values prevail in the political domain is less a matter of scientific facts as it is a matter of political organization allowing access to some values and blocking others. This brings us to the political-institutional analysis of health policymaking.

Analysing public health politics: a basic toolkit

There is, then, a whole literature critiquing the idea that evidence should be produced according to rigid biomedical standards and then move into practice. One kind of knowledge that is necessary to bring public health into politics and policy is knowledge about politics: the systems that shape policymaking and policymakers, and the practical skills of engagement.

In terms of understanding the systems that shape policy, what research and practice in public health politics require is an approach to identifying key political factors in particular countries or systems that shape the development and use of both knowledge and political will. Ultimately, every political system deserves its own analysis¹⁹ above all for the benefit of those who work in it. But comparatively, there are two core questions to ask of any system. The first question is what shapes the political options for public health? The second question is what are the political techniques and the strategic landscapes of the political systems in which these political options are played out?

To start with the first question: Constitutional structure, such as the division of powers within government, the extent of regional and local autonomy, and the role of the courts, shapes political options. For example, consider decentralized governance. The WHO has called for a 'command and control' approach to health emergencies.¹⁹ That advice is simply pointless if given to a country such as Canada, Spain or the USA whose constitution lodges public health powers in the states rather than central governments.²⁰ Likewise, it is tempting to ignore the role of federal states in social insurance systems, but it is also almost impossible to understand how health expenditures work if you do.^{21,22}

Local government has a more variable constitutional status but is often an overlooked part of social and health policy. Its role is very different in different countries but tends to be largest in areas of great relevance to public health such as social care, restaurant inspection, education and school health, and local built environment.

The real meaning of constitutions, such as the powers of a president, legislature or court, change, but at any given time they matter a great deal. Thus, for example, the impact of the populist radical right varies with the kind of political system they win office in (3). The mechanics of getting rid of a leader vary greatly and make a US or French President far more entrenched than a German or Spanish prime minister, who is in turn less vulnerable than a UK prime minister.

Economic structures also shape options. Public health policy analysts accept that determinants of health lie beyond the health system, in the wider economy and structure of inequalities. Economic outcomes are often politically determined. But in their policy analysis, they tend to focus on the government's tax and expenditure decisions. That is a barely accurate reflection of life in the decentralized economies of the English-speaking countries, but fails to reflect the strength of organized labour markets in shaping inequality, gender relations, and the nature of employment and education in other countries.²³ Thus, for example, the status and organization of public health is dependent on healthcare funding schemes. In welfare states with a social insurance scheme, public health runs the risk of having public health primarily narrowed down to into medicalized interventions in basic insurance benefits²⁴. The political economy of public health, such as its relationship to social insurance and different kinds of labour markets, is a major area where public health research and applied education for our students is needed.

The second question is how the strategic landscape shapes politicians' actions. There is a major divide between public health and political science here. Health policy writers have a strong tendency to assume that enlightened health policies depend on 'political will' that can overcome inertia and industry lobbying. Adding sophistication to this framework generally involves analysis of framing and perhaps of Kingdon's multiple-streams framework for agenda-setting.²⁵ Despite the empirical power of multiple streams analysis, excessive use of it risks reinforcing the focus on heroism and voluntarism in the public health literature by suggesting that sheer will, sufficiently adept framing or policy entrepreneurship leads to the adoption of policies. That is not the case; will and framing are not the only variables predicting political success. Even successful framing can produce perverse results: a focus on inequalities in health directed policy attention not to the underlying social and economic inequalities, but rather to public health interventions that were never likely to reverse the inequalities of modern society. The result was failed health inequalities policies and a diversion from addressing real determinants of health inequalities.²⁶

Political scientists generally avoid such voluntarism and examine the components and circumstances of political will. This includes the study of 'interest groups' as well as the different systems of interest representation. The articulation of different industry and public health interests with political systems varies, with very different effects on health policy. For example, in some countries political access is rigidly structured, often to the detriment of outsiders such as new social movements, while in other systems such as the EU or the US interest representation is chaotic, overrepresents groups and people with money, and is most likely to produce no change at all.^{27,28}

A second topic is partisanship. Political parties structure modern politics because they are the teams on which politicians compete for power. They mattered enormously in the post-war years of stable party systems, and their more recent crises and reconstitutions also matter enormously (as a quick look around Western Europe should show). Thus, policies such as tobacco control or global health aid are often adopted by parties in the hope that they will resonate with particular groups of voters.

It is possible to add topics to this list. The whole field of political science exists to explore and develop nuance with regard to politics and policy. For instance, a free and independent press, rule of law, and a professional, non-partisan bureaucracy have been identified as important components of a democracy. This is true and a concern for anybody who supports democracy and is observing the situation of the press and rule of law worldwide.

But for analytical purposes it might be better to leave with a truth that works almost everywhere: politicians, and parties, are motivated by the electoral imperative to seek and stay in office.²⁹ As a result, politicians on any issue will be looking to claim credit for good outcomes and avoid blame for bad outcomes. If the issue is one that lacks 'traceability' such that it produces no obvious credit or blame, politicians will take positions that please their followers and target voters.³⁰ Politicians do not just pay off supporters with broadly based policies and agreeable position taking. They can also pay them off with specific benefits and corruption such as preferential access to contracts. If we start from this logic, and understand how given politicians think about credit, blame and traceability in a given political system then we will not be far from understanding them.

Conclusion and implications for public health education, research, political strategy

If we want to understand policies and outcomes, we need a more sophisticated understanding of political systems and institutions that shape the political processes and conditions for policy adoption. If we want to effectively gain access to policy decision-makers and influence their decisions, generating evidence of how political

systems, institutions and processes mediate the success or failure of public health advocacy and policies is a crucial first step. Without such intelligence, public health interventions are not likely to generate sustainable health impact. There is a need for:

- (1) A public health political science generating evidence on (i) the political options for public health appropriate to the characteristics of the constitutional order, the political economy and (ii) the political techniques and strategic landscapes of interest representation and partisanship.
- (2) A political action repertoire for politically informed public health practitioners working at the nexus of different policy sectors; disciplines; and science, practice and political arenas.

In terms of teaching, it would be valuable for all public health and medicine programmes to have a serious academic course on politics, preferably one that is mandatory for public health students. Such a course would both teach about the broad landscape of politics such as party systems and interest groups, and also teach professional skills such as effective lobbying, media engagement, social media and the mechanics of consultation (how and when governments solicit advice). There is a big difference between coverage of politics that suffices to accredit a programme—a low threshold—and coverage that trains future scholars and practitioners to understand and maximise the impact of their work. Programmes that cannot hire their own specialist in public health politics might consider taking advantage of resources in politics elsewhere in the university.

In terms of research, the key call is for editors to raise their standards. Statements about politics in the public health literature should be held to the same rigorous standards as statements about epidemiology. Editors, when they see a submission with a substantial political component, should make extra efforts to secure referees who are expert in research on the relevant areas of politics and policy. Likewise there is a place at conferences for stories from practitioners and tales of political engagement by prominent researchers, but too many such presentations create the impression that all we need is passion and evidence. Fewer personal stories and more structured attention to the conditions and reasons for political action would be beneficial. Financial support for policy and political analysis in health research should be part of funders' portfolios if they are truly concerned about translational science. Compared with many areas of public health research, good political research can be very cheap.

Finally, political strategies are always context dependent, which makes it hard to give general advice. But there are a few points that apply in most systems. First, respect political professionals such as lobbyists, staffers, civil servants and politicians themselves. Politics is a full time job, their expertise in politics is crucial, and amateur policy making works about as well as amateur epidemiology. The most effective advocates know and can work with scholars and *vice versa*. So do not define the problem of having influence as that of starting a second political career. Define the problem as working with people who are political specialists and can help. Likewise, it is possible to engage in politics almost everywhere without becoming a party activist. Second, make use of resources that are already available such as university press offices. Third, skills such as effective use of social media, organizing techniques, testifying before legislators and input into public consultations are not difficult to acquire, and public health organizations should be eager to help. And finally, persist. Advocacy, policy, and politics all have ample doses of frustration as well as luck. Only those who are around at the moment can seize the moment to do good.

Public health literature frequently combines great rigour in traditional fields such as epidemiology with empirically unfounded and highly normative pronouncements about what policy makers do or ought to do. This is strange: a field whose basic justification is the diagnosis and treatment of social ills shies away from actually thinking about how to treat them efficaciously. Political science

should be the translational research of public health because politics is usually what stands between our findings and effective action. We thus call for public health to extend its rigorous analysis to politics, drawing and building on the insights of political science to fulfil the promise of public health that it strives to cure society's ills, rather than just diagnose them.

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Key points

- 'Science can identify solutions to pressing public health problems, but only politics can turn most of those solutions into reality.'⁶
- Which values prevail in the political domain is less a matter of scientific facts as it is a matter of political organization allowing access to some values and blocking others.
- Political systems shape the political options for public health and the conditions for a mix of political techniques appropriate to the strategic landscapes of interest representation and partisanship.
- Editors, teachers, and researchers in public health could all help improve the quality, quantity, and usefulness of politics research to the benefit of the academic field and the public's health.

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