Commentary on Sparer and Beaussier

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Michael S. Sparer and Anne-Laure Beaussier have written a very important comparative analysis of public health policy across the United States, England, and France and conclude that public health in the United States is surprisingly robust, in part due to a fairly interventionist federal government, compared to the more meager, locally focused public health systems in England and France. Sparer and Beaussier base this conclusion on two main facts: "First, the United States spends more than nearly all Organisation of Economic Co-operation and Development nations on prevention, both on a per-capita basis and as a percentage of overall health spending. Second, the United States outperforms its European peers on several public health and prevention metrics (including tobacco use and dangerous alcohol consumption) while lagging behind on others (such as obesity and opioid use)."

I applaud this interrogation of public health policy. A wealth of research analyzes the politics of health policy, which often focuses on unraveling the complexity of health care coverage or financing policy and health delivery systems, but far fewer studies focus on the politics of public health. Yet, while Sparer and Beaussier's analysis raises fascinating questions and thought-provoking explanations for cross-national differences, it also illustrates how difficult it is to analyze public health policy. It is difficult because policies that come to be called *public health policies* are politically constructed. Because it is a political construction, the definition of public health changes over time, across space, and by context. In this short commentary I provide a few examples, starting with the US

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case, to highlight this point and discuss implications for understanding the politics of public health.

When the field of public health moved from a primary focus on sanitation and communicable disease in the nineteenth century to infectious disease with a focus on personal hygiene and control of chronic diseases in the twentieth century, public health leaders argued that public health needed to focus on the individual. With this focus, they also argued within the profession that the distinction between curative and preventive care was artificial (Winslow 1926; Grogan 2012a, 2012b). However, because private physicians were actively making claims on the state to maintain their jurisdiction over medical care to individual patients, they viewed public health as a threat. In response, in this context, when public health leaders felt under attack, they argued for the distinction and defined their provision of services to individuals as "only prevention." There was no clear scientific definition of *prevention*. Instead, prevention was determined to encompass diseases that private physicians were unable to address or were uninterested in, for example, tuberculosis, cancer, venereal disease, and maternal and child health. Throughout most of the first half of the twentieth century these services were provided only by municipal and local health departments or voluntary health agencies with public health funds. Today, all of these conditions are treated by private physicians in health care facilities. These treatment facilities may receive public funding, but the services rendered are not typically referred to as public health prevention services. What changed over time was not a decrease in public health provision but political claims as to what should count as public health prevention.

We see a similar phenomenon when thinking about the meaning of US investments in building up the National Institutes of Health (NIH) and the US hospital system. Sparer and Beaussier note that through NIH funding the federal government funneled billions of dollars to academic medical researchers, and also invested billions to stimulate hospital construction and modernization. In their view, these examples imply that public health was marginalized. However, public investments in medical research and in the health delivery system were initially thought of as public health investments. The NIH was started and developed by public health leaders in the US Public Health Service and advocated as crucially important for advancing the health of the public. Moreover, the Public Health Service took an active role in building up the US health service system, because its leaders believed that a particular construction of this system—one based on the concept of regionalism, which ironically put the academic medical

centers and tertiary hospitals at the pinnacle and center of this system and community hospitals and public health centers at the periphery—would best enable public health promotion and prevention. Under this view, public health leaders and the profession needed to be centrally involved in the development of medical care, because medical care needed to emphasize public health (Stevens 1989; Fox 1986).

Even by 1965, some public health leaders began to worry that these major federal investments overemphasized research perhaps to the detriment of expanding local public health departments. However, today, we don't even count them as public health investments, because our political construction of what public health is has drastically changed, and because no public health leader today would claim them as such. But this is exactly the point: What is the public health history that is being told? A history based on our definition today? One based on what public health leaders claim it to be at any given point in time? Or one based on some other external definition that can be held constant over time? No one history is the right one; each definition will tell a different story.

A few more comparative examples will help clarify the importance of public health historiography. In highlighting recent differences in public health policy between France, England, and the United States, Sparer and Beaussier note that "population health" and "population health management" are used more often in the United States, whereas England and France tend "to encourage a more individualized approach to population health." Yet, it is unclear whether this claim is based on differences in discourse or actual policy initiatives. It is important to analyze policy discourse—claims made about public health policy—separate from actual policy, since discourse can often tell us more about ideological culture (or fads) in a particular place and time. However, when Sparer and Beaussier explain that "public health gained additional prominence through the notion of *sécurité sanitaire*," it is unclear whether that claim is based on what public health leaders in France said or actual policy. They list "monitoring the quality of care" as an example of public health policy under the *sécurité sanitaire* initiative in France, yet monitoring quality (or evaluating effectiveness) would not typically be labeled as a public health policy in England or the United States. So is the important point here a difference in actual policy or a difference in how public health is defined across these nations?

Similarly, the United States is said to focus more on a population-based approach to public health because it uses the terms *population health* and *population health management*. But what US policies undergird this population-based approach? It might be, as Sparer and Beaussier conclude,

that "the US system of public health fares rather well compared to other Western nations," if we focus on one particular slice of public health, such as prevention services. We could call prevention services an example of public health, but ironically, the United States might do better in this domain because it is provided by the health care system and paid for by public and private insurance, not institutions we typically associate with the public health system. And "interest in public and population health" might have grown more quickly in the United States only because the United States is particularly adept at latching onto policy panaceas without actually adopting meaningful change. Again, this may be more about discourse in the United States than about actual policy. Finally, the United States might spend more on prevention and public health than do England and France only because each country puts different items in the public health bucket. For example, if we count social services (or "social medicine") as part of public health, which those who believe in the social determinants of health would advocate for, then a very different picture emerges (Bradley and Taylor 2013; Stone 2017). In short, because public health is politically constructed, any comparative analysis must lay bare who is making the claim, what the claim entails, and what exactly is being compared.

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