Editor's Note

The Hidden Strength of Prevention Politics

I recently heard a public health leader tell this story: just after 9/11 Surgeon General Richard Carmona was called to testify before Congress to brief political leaders on the threats of bioterrorism and our nation's level of public health preparedness. After an extensive question-and-answer session in which many scary disaster scenarios were discussed, reporters asked Carmona, "What is our nation's biggest public health threat?" He answered, "Obesity."

As this themed issue demonstrates, public health politics can be approached from many directions. In fact, the very definition of public health is so broad that many different components of its jurisdiction can be emphasized at politically opportune times. It is this juxtaposition between what public health leaders and "science" tell us and how politicians and the public react that best illustrates the different research questions and quite different answers provided in this issue by Rick Mayes and Thomas Oliver, on the one hand, and Lars Thorup Larsen, on the other.

Mayes and Oliver ask why government investment in public health initiatives aimed at reducing chronic disease is so politically difficult. Their argument is that there is little investment in preventing chronic disease because such policies and practices have four main structural political disadvantages: benefits are dispersed and delayed; benefactors are unknown and taken for granted; costs are concentrated; and policies are often morally contentious and clash with social norms.

Larsen is motivated by a different view of state investment in public

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health. He details the genealogy of lifestyle prevention—a phrase that denotes efforts to change lifestyle behaviors to prevent chronic disease—as a policy idea and shows, through U.S. and Danish public health reports from the 1970s through the 2000s, how lifestyle prevention spread and gradually was interpreted by governments as a more promising way to control chronic disease than acute medical treatment.

Mayes and Oliver are interested in government spending, and they see little investment in public health, arguing that prevention is a "political lightweight" and that public health prevention policies suffer from political weaknesses. Larsen, in contrast, focuses on the lifestyle prevention idea—its framing and crafting over time—and finds substantial state investment in the *idea* as the most promising policy solution for attacking chronic disease.

Because of the power of the lifestyle prevention idea, Larsen contends, key government documents specifying public health goals (e.g., *Healthy People 2000*) often present past lifestyle prevention policies as more successful than the evidence might actually show them to be. Larsen implies that the widespread promotion of lifestyle prevention policies is not backed by solid evidence about how governments can effectively change lifestyle behavior. That is, while there is evidence that obesity is associated with the onset of various chronic diseases, there is very little evidence about which policy designs effectively change behavior to reduce obesity. Moreover, Larsen points out that there is much less evidence in the literature to understand how *changes* in obesity levels are associated with changes in chronic disease. If you lose weight at age forty or fifty, does it make much of a difference?

Adam Oliver and Lawrence Brown's article seems almost a response to Larsen. While they are silent on Larsen's main argument, they focus on a particular policy tool—user financial incentives—and ask whether there is sufficient evidence to conclude that financial incentives induce health-related behavioral change. Their review of the literature suggests that payments for some aspects of medical adherence can change behavior and, as such, may reduce health inequalities. However, they are also quick to qualify this general statement by acknowledging that payments for *sustained* behavioral change—payments associated with the biggest lifestyle problems, smoking cessation and weight loss—have shown little long-term effect to date.

My Behind the Jargon essay on prevention spending can also be read as a response to Mayes and Oliver's underlying assumption that prevention spending in the United States is persistently low relative to spending on

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medical treatment—about 3 percent compared with roughly 80 percent of total U.S. expenditures. I look under the hood and try to decipher what counts as prevention spending and, more important, what is typically not counted and why. In the short-essay format of this special section, I can only hint at the reasons why, but I suggest that public health policies benefit from a type of hidden politics related to definitional ambiguity as illustrated in the story above about Carmona.

This definitional ambiguity is on display at the global level as well. Steven Ney documents the existence of three global health narratives: choice, rights, and stewardship. Each provides a different story about the global health crisis—its underlying assumptions, the identification of the policy problem, and the offered policy solutions. By detailing the organizations behind the narratives and their strategies, he is able to show how organizations emerging from particular sectors—the market, the state, or civil society—are closely associated with particular frames, and he is able to consider whether organizations in partnerships are more likely to create policy documents with a plurality of narratives as opposed to "pure" narrative frames.

Ney connects his narrative analysis to larger debates about global health governance. He grapples with a central and crucial question: does unstructured and unregulated pluralism in global health governance (what David Fidler [2007] termed "open source anarchy") undermine the ability to properly pursue global public health interests and is therefore ultimately unfair and ineffective? By analyzing whether these competing global health narratives show evidence of policy actors appropriately "puzzling through" messy policy challenges in the way Hugh Heclo (1974) suggests is beneficial, Ney's answer is appropriately nuanced. On the one hand, the predominance of "pure" narratives suggests modest learning among contending policy actors, where the issues appear stuck in inherently conflictual polarizing debates. On the other hand, he questions whether priority setting and consolidation—the antidote offered in the literature to correct power problems in open source anarchy—are the appropriate response. Finding evidence of a range of narratives on display under open source anarchy and arguing that effective puzzling relies on multiple viewpoints, he recommends more pluralism with a deliberate equalization strategy, with the hope that all voices would receive a fair hearing.

Peter Jacobson and his colleagues also consider public health governance but on a much more local level in the United States. Focusing specifically on the legal environment for public health preparedness in nine states, they find a considerable gap between how public health prac-

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titioners perceived preparedness laws and what the law actually requires. Through interviews they identify the primary causes of the gap as the lack of legal training for local practitioners and the difficulty of obtaining clarification and consistent legal advice. In this case where the laws are set, Jacobson et al. call for a clear and strong regulatory structure where there is some assurance that public health preparedness laws would be implemented as intended.

What is perhaps most clear from this themed issue is the enormous range of topics and the extreme variation in politics, all under the rubrics of "public health" and "prevention." Lurking between these pages is serious disagreement about what is even meant by the terms, whether government spending is large or small, has increased or decreased, whether its politics is favorable or unfavorable, and whether its regulatory structure in even one domain can be clearly explicated.

Public health is an established field with solid journals that help us understand the prevalence of various diseases, the factors associated with disease, and the effectiveness of various preventive measures. However, very little is understood about the politics of public health. This themed issue begins to unravel its many layers, but it is just a beginning, and so as much as anything this issue is a call for more research!

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References

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