commitment and methodology can diminish and even eliminate these biases, and this is particularly important in areas that are, by their very nature, highly controversial, such as research on politics and health. The risk of being perceived as ‘propagandist’ is too great to be ignored. But that risk can be diminished through rigor, clarity and transparency, exposing one’s own work to debate and scrutiny. With these conditions, there is an enormous need to study a critical question in any democratic society: Do politics matter? We should realize that if the answer to this important question is no, then we—those living in democratic societies—are in deep trouble. Democracy does not work and we live under technocratic regimes. Fortunately, the evidence shows that the answer is yes, politics do indeed matter. Political parties, for example, do shape health outcomes, although not always in the direction one expects.

Actually, this question of whether politics matter, while new in public-health research, is not new in the social and political sciences. The literature in these fields contains a relatively long list of useful references. In Europe, the founders of this type of study are Walter Korpi and his collaborators. Korpi’s classic study, The Democratic Class Struggle, initiated an extremely productive scholarship. Korpi looked at how political traditions and the power relations they represented (class, but also gender) had affected the nature of the welfare state and the well-being of the population.

In the health field, I followed that tradition of inquiry and initiated work in this area in 1989, with the article ‘Why Some Countries Have National Health Insurance, Others Have National Health Services, and the U.S. Has Neither’. Extensive research has been developed since then, and very valuable work has been done on how political traditions affect health policy. But, until recently, no such work has been done relating political traditions to health outcomes. And here, the evidence that political variables have an impact on health outcomes is robust. For example, in Europe, political parties committed to redistributive policies (through a range of social policies) have been more successful in improving the health of their populations than those without such commitment. Less clear evidence exists, however, on the impact of these political forces on reducing health inequalities. A political force can be very successful in reducing social inequalities, but not so successful in reducing health inequalities. At least, this is what some scholars claim, although others report different outcomes and conclusions (see the inequalities series in the International Journal of Health Services). Thus a fruitful debate is underway that, no doubt, will continue for some time. This debate is also raising important issues about the methodologies used in these studies and their conceptualization. For example, many studies have used the size of public social expenditures as an indicator of the size of the welfare state—an indicator that may be insufficient because, among other reasons, the size may depend more on demographic factors than political variables. A rich debate is taking place on many fronts, and especially in the pages of the International Journal of Health Services. These studies are breaking new ground and they need to be done. As Virchow wrote, ‘It is the duty of society through the state to protect and promote the lives and health of its citizens’. We, public-health professionals, therefore, should also study the state and its governance in democratic societies to see how it does what it is supposed to do.

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Politics and health: policy design and implementation are even more neglected than political values?

It is surprising that political phenomena have not been more prominent in public-health research. But there can be no doubt that politics do matter. It is impossible, for example, to understand health inequalities policy in England in the past two decades without acknowledging the ideological differences between the Thatcher/Major and the Blair/Brown governments. Even within one party tradition there are also many examples of different Ministers wanting to try to put their personal imprint on policy. The recent change from a Blair to a Brown-led government in England helps in part to explain why health inequality policies there are now being refreshed.

But despite clear evidence that politics matter it is not difficult to see why many scholars shy away from an explicit focus on this. Much of politics is about values and these do not lend themselves easily to scientific examination. This is not to suggest that they should be ignored, but the dividing line between scholarly endeavour and personal politics is an uncertain one.

The constraints are less evident in cross-national work where a rich vein of studies, that have examined variations between nations in conventional population health outcomes such as infant mortality, has paid particular attention to those factors that might be seen as the outcomes of purposive political choices. Many of them suggest that more progressive tax systems and universal welfare cultures are associated with improved population health outcomes. For example, Chung and Muntaner1 report that ‘more protective types of welfare state regimes, namely the group of Social Democratic countries’ are associated with lower rates of infant mortality and low-birth weight. It is not easy to draw general inferences from such studies, though, because they use different samples of countries, outcome measures and methods of investigation. Although there seems to be a growing consensus that discretionary...
characteristics of welfare states are associated with variations in population health outcomes it is less clear that this is as true of health inequalities. There are as yet only a small number of studies that try to investigate the links between classical welfare state models and health inequalities. Those that have been published, however, are beginning to cast doubt on widely held assumptions that Nordic welfare states, for example, do better than more liberal ones, at least in Europe.

But even these new areas of study are perhaps too narrowly based. Any serious consideration of the impact of political science on public health must cover a broad territory. The American Political Science Association defines political science in a way that should encourage as much interest in the practice of government as in politics per se (http://www.apsanet.org/section_517.cfm).

If politics can perhaps be represented as the art of making and marketing policy choices, then government is to a significant extent about designing and implementing policy proposals. From this perspective, and certainly in relation to the study of health inequalities, it is arguable that government is even more neglected than politics.

In most countries that have formally adopted policies in relation to health inequalities it is difficult to identify much that goes beyond rhetoric and aspirational targets. Even in England, where it is claimed that a strategic plan of action has been in place for several years, it is difficult to find evidence that policies, interventions and investments have been conceived, designed and implemented in purposeful ways that have any realistic prospect of achieving desired outcomes.2

It remains largely true that ‘policy making about health inequalities takes place in a fog of disagreement about goals, controversy about causes and uncertainty compounded by ignorance about means’.3 One of the relatively few studies to take this topic seriously reports that ‘implementation is hampered by deficiencies in performance management, insufficient integration between policy sectors, and contradictions between health inequalities and other policy imperatives’.4

Fortunately this situation is, somewhat belatedly, beginning to change. Perhaps the best example of a focused strategy with a clear action plan to achieve specified reductions in inequalities can be found in England where an important new report about the failure of the infant mortality target to make adequate progress illustrates the nature of the implementation failure that has occurred and shows the importance of audit and review, widening the scope of interventions (to include wider determinants of health) and supporting local implementation efforts—if the situation is to be improved in future. New plans start to address important questions of policy implementation and feasibility that increase the probability that desired outcomes will be achieved.

European Journal of Public Health—Comments on Ken Judge’s article

Professor Ken Judge underlines the importance of undertaking research on the politics of health policy. We agree on that. But I do not share his skepticism about the possibility of studying ‘values’ (I assume that he means political values). Political Sciences study not only values but, most importantly, power (class, gender, race, national and other types of power relations) and its expression through political representative institutions. The analysis of how power is distributed in a society, how power is expressed, and how power shapes the nature and quality of a society, including its health outcomes, is of paramount interest. This should be the subject of scholarly work using rigorous methods that add credibility to its intellectual production. It is precisely because the subject of analysis is power and its expression through public policies that researchers are reluctant to study it. Their tenure often depends on powerful institutions not likely to welcome these types of studies.

We can see, for example, that most of the emphasis by social epidemiologists in the growing field of social determinants of health is on the psychosocial and cultural determinants—rarely on the political determinants. This selective focus is not the result of the difficulty of studying the subject, but rather is due to its political sensitivity. The psychosocial and cultural have an individual focus, while political factors require an analysis of collective power relations that can produce some headaches for those who dare to conduct such analyses.

Avoiding political analysis and prescriptions, however, is like a clinician diagnosing a disease but not prescribing a treatment to resolve it. In the United States during the conservative 1980s, there were epidemiologists who thought epidemiology should not deal with policies. This position, fortunately, has since been discredited. But, epidemiology and public health should go one step further, since it is impossible to study policies (and evaluate policies) without understanding politics. I am glad that Prof. Ken Judge and I agree on this point.

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