Public Health in a cross-national Lens: the surprising strength of the American System

Michael Sparer, Anne-Laure Beaussier

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Michael Sparer
Columbia University

Anne-Laure Beaussier
Sciences Po Paris, Centre de Sociologie des Organisations

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Critics of the US health system point out that we do not get good value for our healthcare dollar: we spend far more per capita than our peers yet rank quite low on various health outcomes. As noted in a recent report, the US has a "strikingly consistent and pervasive" pattern of poor health outcomes when compared to other high-income nations (Shorter Lives, Poorer Health 2013). The effort to explain this (dismal) cross-national performance often focuses on the subordinate status of public health; presumably the key to a higher performing US health system (and better health outcomes) would be a

higher percentage of the health care dollar on prevention and public health (and a lower percentage of spending on specialty and acute care). Moreover, the subordinate status of public health in America is presumably rooted in health care federalism: the decentralized American system arguably fares poorly when compared to more centralized systems like England and France.

This paper considers these assumptions by comparing public health in the US, England and France. The comparison demonstrates that each of the three nations places a far higher financial and cultural value on acute care and bio-medical research than on public health and prevention. That the US has such a fondness for high tech and individualized medicine is perhaps not surprising, but that there is a similar pattern in England and France is less expected.

Three additional findings are even more unexpected. First, the US outperforms its European peers on several public health and prevention metrics, including tobacco use, alcohol consumption, and use of clinical preventive services (Commonwealth Fund, 2014). Second, the US spends a comparable proportion of its health dollar on prevention (3%), which is more than France, a bit less than the UK and right around the OECD average) (OECD, 2005). Third, these results are due at least in part to a surprising federalism twist: while England, France and the US all delegate significant responsibility for public health to local governments, federal officials in the US have had a longer and deeper engagement in public health policy than have their European counterparts, a trend that is at odds with the more general inter-governmental trends in the three nations.

We begin by summarizing the evolution of the public health systems in the US, England and France, noting the common roots, patterns and obstacles. We then examine

the renewed interest in public and population health in all three nations, and (tentatively) suggest reasons why this trend might grow more quickly in the US than in its European counterparts.

Public health in the US, England and France: Common Roots and Patterns

Despite their radically different health care systems, the US, England and France have a shared public health history, including a bias toward local (as opposed to national) governance, a cultural preference for curative medicine (over public health), and the absence of a strongly mobilized public health constituency.

The United-States, where the legitimacy of the state and especially of the federal government to intervene in people's health is arguably the more fragile, is a good case to begin with. American history includes an ongoing debate over which level of government should do what. Back in the 18th century, for example, the anti-federalists advocated for local autonomy, boycotted the Constitutional Convention, and argued that the proposed document was likely to lead to a new (American-styled) monarchy. At the other end of the spectrum, Alexander Hamilton pushed for a strong federal government (fueled by a powerful executive branch). James Madison proposed a middle-ground, a large but weak national government, with its power constrained by the separation of powers and other institutional checks. The constitution that emerged provides significant support for each view, leaving to future generations the endless federalism debate that remains with us today.

Importantly, however, the election of Thomas Jefferson in 1800 ushered in a longstanding era in which states' rights and local autonomy dominated, and limited government became ingrained as a key component of American political culture. And while the states clearly had the authority to act, they generally delegated to local communities two kinds of health and social services tasks: first, providing classic "welfare" related services to the so-called "deserving poor" (those outside the workforce through no fault of their own), and second, providing basic public health services in their communities.

The focus on public health increased during the industrial revolution, with its overcrowded cities and increased international commerce, both developments leading to a rise in infectious diseases and mass epidemics. In the late 1700s, for example, several cities along the eastern seaboard created local boards of health to respond to outbreaks of yellow fever, both with sanitation programs and quarantine policies. There was, however, a clear pattern beginning to emerge: local officials would provide short-term fixes (improved sanitary conditions and public education campaigns) but scale-back such efforts (and disband the boards) once the epidemic was contained, prompted by opposition from the business community as well as the anti-government political culture that was increasingly entrenched (Fee and Brown, 2002).

In this period, it was generally considered unwise (and perhaps even unconstitutional) for the federal government to enact health and welfare legislation. But there were exceptions, most notably the Marine Hospital Service (MHS), which provided medical care to sailors and soldiers. There also was a brief federal foray into public health, the Vaccine Act of 1813, under which a "National Vaccine Agent" distributed

smallpox vaccine to thousands each year, a program that ended in 1821, after the accidental distribution of the wrong vaccine led to ten deaths (Singla, 1998).

The political dynamic changed somewhat due to the rise of the so-called sanitary movement in the mid-19th century. Several factors were key. First was the emergence and growth of the field of epidemiology, prompted by John Snow's famous decision to remove the pump-handle from the source of contaminated water in London, thereby ending a devastating cholera outbreak nearly overnight. Second, and closer to home, were the terrible conditions in the civil war military camps, which convinced President Lincoln to create a national Sanitary Commission to investigate. And third was the (slow) acceptance of the reality that horrific social conditions, rather than moral decadence, led to the high rates of disease and early death among the poor.

In this context, cities like New York and Chicago established the first permanent departments of public health, followed by the creation of the American Public Health Association (APHA) in 1879, which had as its goal "the advancement of sanitary science and the promotion of organizations and measures for the practical application of public hygiene. (Duffy, 1990). Meanwhile, public health activists pressed for a federal public health agency, but national leaders were reluctant, given the bias toward local autonomy and control, as well as the lingering fallout from the ill-fated Vaccine Act of 1813.

The push for federal action increased, however, with the influx of European and Caribbean immigrants, the perceived need to prevent entry to persons with a contagious disease, and the often-inadequate local response to smallpox, malaria and yellow fever epidemics. In 1897, for example, a smallpox epidemic swept through the southern states, overwhelming state and local public health capacities, and prompting an aggressive

federal response led by the MHS. Over the next twenty years, the MHS increasingly focused on its public health mission, and in 1912 it was renamed the US Public Health Service (Sledge, 2017). Meanwhile, the federal public health role expanded again in 1921 when Congress enacted the Sheppard-Towner Act, which provided federal funding to the states to create prenatal clinics and fund a range of pregnancy education programs. While Sheppard-Towner funding ended in 1929, the program was reborn as Title V of the 1935 Social Security Act. The Social Security Act also included (in Title VI) millions to support the state and local public health infrastructures.

With a more engaged and effective public-sector infrastructure, and a relatively defined mission and focus, the first half of the 20th century surely ranks as the golden era for the public health community. Between 1900 and 1950, for example, life expectancy increased from 47 to 68, a remarkable 21-year gain that is even more impressive when compared to the 9-year gain (to 77) during the second half of the century.

What explains the extraordinary gains early in the 20th century? The keys were public health interventions that led to working sewage systems, safer food, chlorinated water, cleaner streets, better workplace conditions, improved housing, more effective prenatal care, and faster and better responses to infectious diseases. These public health interventions were led by the nearly 3000 local health departments spread throughout the country, supported by their inter-governmental partners at both the state and federal levels.

Looking back the other side of the Atlantic, the overall story and timing of the development of public health looks fairly similar and share both the philosophical debate

about individual versus collective responsibility and the center-periphery tensions over the level of government most appropriate to deal with public health. These similarities include early beginnings and promising advances from the mid-19th century to the first half of the 20th century, as well as rapid gains in life expectancy due as in the US to better sewage and water treatment, improved housing conditions and so on. Both in France and England once powerful conservative movements seeing poor individual behaviors as a major cause of bad health were gradually overcome by the recognition that devastating social and economic conditions, linked to industrialization and urbanization, were contributing to outbreaks of infectious disease, a view that gained strength with the emergence and development of the science of epidemiology.

France represents an interesting case to study in this perspective, as the country is often analyzed in international comparisons as an archetype of a centralized state deriving from its Napoleonian tradition of centralization of power. But the country's early debates over public health back in the 19th Century display striking similarities with the US, one of philosophical nature and the second more institutional over the appropriate level of government to provide health services. Firstly, the 19th Century France was far from being the generous welfare state often described in the literature which in fact only emerged in the aftermath of WWII. At the time, conservative movements were strong and consistently resisted the enactment of collective health care structures, in the name of a so-called *ethics of prevoyance*, emphasizing individual responsibility over structural determinant of health, blaming poor people for their lack of cleanliness, their poor behavior (alcohol, sexual behavior) and for their lack of foresight. With the exception of vaccination against smallpox, where the central government in 1808 ordered 2 million

doses and sent *vaccination doctors* in rural areas to reach communities and fight a devastating outbreak, national action remained ill-accepted, of limited scope and de facto left to ad-hoc initiatives from the municipalities and departments (Bourdelais, 2003; Tabuteau, 2010; Bergeron, Castel, 2014).

Similar to the US, public health initiatives at the national level developed from 1870 on, when ideas of solidarity gained more strength nationally (Tabuteau, 2004). A series of Public health acts, including the Public health act of 1902, provided a legal framework and introduced a range of policy initiatives such as new public physicians, free medical assistance for the poor, an obligation to respond to infectious diseases, and a national committee on public hygiene. These measures were reinforced after the Spanish flu outbreak in the 1920, with the creation of a public health ministry (Morelle, Tabuteau, 2015). It is worth noting that the primary responsibility for the delivery of public health services remained a prerogative of the local government, as public health regulation strengthened communes' responsibilities adopt and enact hygiene regulation, as well as stricter housing hygiene rules.

In the 19th century England of the 'poor laws' and heavy reliance on the distinction between 'deserving' and 'underserving' poor for the delivery of social services, the moral debate about the social vs. individual determinants of health was also important. Similar to the US, in England early public health interventions, back in the 18th century, were first targeted on the navy, the army and the immigrants' health in attempts to contain outbreak and infectious diseases. Public health initiatives were then supported by the social medicine movement including Edwin Chadwick, sanitary

commissioner and poor law reformer, and Florence Nightingale. These 'sanitarians' campaigned for sanitation measures and hygiene, such as sewage and improvement in water systems. The Public Health Act of 1848 established a central board of health, but delegated responsibility for clean water, drainage and sanitation more generally to Local Authorities (LAs).

Over the next several decades, the central government enacted additional public health legislation, further reinforcing the local role in ensuring clean water, basic sanitation, safe food, and hygienic conditions more generally. The Public Health Act 1866 created drainage districts and reinforced the duty of LAs to detect nuisances and act upon them. The Public Health Act 1875 sought to combat filthy urban living conditions by requiring new residential constructions to include running water and an internal drainage system. The Act also required local boards of health to have a medical officer and a sanitary inspector, to ensure that regulations on food, housing, water and hygiene were enforced. This succession of acts was consolidated by the Public Health Act 1936. The following years constituted the "golden age" of public health in England, with social medicine developing through medical officers for health and public health clinics run by local authorities besides the private practices of general practitioners gradually eradicating common infectious diseases.

Public Health in the US: Increased Marginalization Post WWII

Following his election in 1932, President Franklin D. Roosevelt persuaded the American people that the federal government needed to take the lead in efforts to respond to the stock market crash and economic depression. Roosevelt promised a "new deal"

between citizens and the federal government, one in which a powerful (Hamiltonian) executive branch would work with state and local governments to enact an array of social protections and economic reforms. Overcoming fierce resistance from the courts (which initially held much of the New Deal to be unconstitutional), Roosevelt engineered a massive increase in the size and scope of the federal government, including the first comprehensive set of federal social welfare programs ("Social Security" and "Aid to Dependent Children"). But while the Social Security Act contained funding for various public health programs (as described above), Roosevelt was convinced by the American Medical Association to drop any effort to enact national health insurance.

Harry Truman succeeded Roosevelt in 1945, and immediately proposed that national health insurance be added to the list of federal social protection programs. While that effort failed, the federal government did soon use the tax code to encourage employers to provide health insurance to their employees, ushering in an era in which the majority of Americans received employer-sponsored private health coverage.

President Truman also presided over the era of American optimism that came with the end of World War II, and included a belief that medical research and specialized medical care would eventually conquer nearly all forms of disease. This assumption prompted the federal government (though the National Institutes of Health) to funnel billions of dollars to academic medical researchers. Congress also enacted the Hill-Burton Program in 1946, which provided federal funds to stimulate hospital construction and modernization, thereby offering more Americans access to the increasingly sophisticated medical care rendered in state-of-the-art hospitals (Thompson, 1981).

Two decades later, in an effort to respond to a perceived physician shortage, Congress enacted a host of initiatives designed to increase the nation's physician supply. These federal policies generally succeeded, as the number of first-year medical students in the US doubled between 1961 and the mid-1980s, along with a dramatic increase in the number of foreign-trained and foreign-born physicians. It soon became clear, however, that most of the new physicians were entering specialist careers, drawn by higher income, higher status, and the general pattern in which most professionals (whether doctors, lawyers, or investment bankers) tend to specialize. Even the new public insurance programs (Medicare and Medicaid) enacted in 1965 to provide a public insurance safety net for (some of) those unable to access employer-sponsored coverage, perpetuated the institutional bias, with reimbursement systems that clearly favored institutional based hospital care.

The growth of the "medical care" system, with physicians emerging as prestigious "life savers," using new technologies, in an increasingly hospital-based health care system, led to dramatic growth in health care spending. During this same time, however, spending on public health seemed less and less necessary. There were fewer and fewer infectious disease epidemics, a growing belief that the nation's sewage and food and water systems were in good shape, and a public-sector focus on the threats presumably posed from communism and the Soviet Union as opposed to pollution emitted from America's factories. The nation was spending more and more on health care, but a smaller and smaller percentage of the health care dollar was going to support the public health infrastructure.

In 1988, the Institute of Medicine issued a blistering indictment of the US public health preparedness. The report noted that 78 percent of local health departments were directed by someone without a public health degree, that there were too few epidemiologists, inadequate labs and computer systems, an aging workforce, with poor communication skills, and too little training in emergency preparedness (IOM, 1988).

The declining fortune of the public health community was exacerbated by three additional factors: distrust of government, perceptions of "us versus them" and the lure of technology and the companies that promise miraculous cures.

Distrust of Government: An American Tradition

The post-New Deal expansion of the public-sector agenda fueled an ongoing backlash against government, a distrust of science, and a perception among many that government is simultaneously inept and dangerous. Long before Donald Trump was calling climate change a hoax, and challenging as fake news the so-called mainstream media, prior Presidents from Nixon to Reagan (and sometimes Carter and Clinton) were praising the virtues of a smaller and less intrusive public sector. This distrust of public authority is especially powerful in the public health sphere, where policymakers (albeit typically at the local level) often are balancing the public good against individual liberty. Rules requiring seatbelts, motorcycle helmets, and speed limits all save lives but can also clash with an American culture favoring individualism over collective action. This is especially the case for more aggressive public health measures, such as efforts by

Michael Bloomberg, the former New York City mayor, to limit the sale of supersized sugary drinks, or to impose other measures designed to reduce obesity.

Making the case for public health even more complicated is that it is often hard to demonstrate a quantifiable return on investment of population-based initiatives. There is, to be sure, a vast literature on the cost savings and cost-effectiveness of "clinical" preventive care. This research finds that some preventive interventions are clearly cost-saving (child immunizations and counseling adults on use of low-dose aspirin), but that the scorecard is mixed on other services, given the costs associated with screenings, treatment, and even longer lives (RWJF Synthesis 2009). There are far fewer studies, however, that examine the return on investment generated by "community-based" public health spending.[1]

The US public health community also occasionally suffers from a credibility gap. In the mid-1970s, for example, a soldier at the Fort Dix military case died from swine flu, prompting fears of a massive and deadly epidemic. President Gerald Ford ordered a nationwide vaccination effort to cover 220 million Americans. Some of the first to be vaccinated, however, developed Guillain-Barre illness from the vaccine. A national outcry ensued, and the President halted the vaccination program after fewer than 40 million were vaccinated. The political backlash intensified as the feared swine flu epidemic never developed. For years afterwards, the public health community was accused of "crying wolf," and falsely raising fears. The current "anti-vaccination"

[1] While thin, there is some literature along these lines, such as one study that found increases in public health spending linked to reductions in mortality rates (Mays and Smith, 2011), a finding consistent with various case studies suggesting a positive return on investment for particular community-based initiatives (Trust for America's Health, 2012).

movement has roots in these sorts of unfortunate episodes (in addition to building off the growing anti-science movement more generally)

The swine flu fiasco illustrates as well another problem for the public health community: their work is invisible and taken for granted when it succeeds (in keeping the water clean and the food safe to eat) but all-to-visible during a public health crisis. For example, the trend toward globalization has enabled infectious disease epidemics to travel thousands of miles and infect geographically diverse populations. The catastrophic impact caused by Zika was only the latest example, prompted both by the horror of babies born with microcephaly, along with fears that the impact was felt (or threatened) on US soil. But a breakout of foodborne illness at Chipotle causes the same political reaction. Public health officials are suddenly in the news, blamed if the epidemic lingers, only to be again ignored once the crisis eases and the newspapers turn to other matters.

One last point. In the 1960s, many local public health departments (especially in rural US communities) began providing clinical services to poor and vulnerable populations without alternative sources of care. But the decision to become an occasional provider of clinical services was controversial, both with some public health leaders (who worried about a loss of focus and mission) and also with some in the general public (who increasingly viewed local health departments as focused on the poor rather than the community at large).

"*Us versus Them"*

There is a seemingly all-to-human tendency to identify with the familiar individual at risk or in trouble, but offer less sympathy for large groups who seem both

different and distant. The so-called "rule of rescue" suggests that people are more likely to respond to individual misfortune (at least in persons who look like "us") than to bad news conveyed in statistical terms (thousands of "them" dying of famine in a far-away land).

At the same time, too many of us are also too willing to blame the individual for health outcomes that are caused by a mix of behavioral and social (and sometimes also genetic) variables. If obesity is due to laziness and poor eating habits then why focus scarce public dollars on persons who have no one to blame but themselves. If addiction or mental illness is viewed as a consequence of moral weakness (as opposed to a not-surprising consequence of social conditions) then why pay for substance abuse or mental health services. Not surprisingly, however, many are more sympathetic if the drug addict or schizophrenic looks like "us," a phenomenon providing an important insight into a polity more inclined to provide aid to (largely white and rural) victims of the current opioid crisis than to (black and urban) heroin addicts in the past.

Technology and the Promise of Miraculous Cures

Critics of the US health care system often complain that physicians deliver too much "defensive medicine," services, tests and procedures prescribed even though they're not "medically necessary." Some blame the nation's medical malpractice system, arguing that physicians order that extra test to protect against potential litigation. Others blame economic incentives, noting that by driving up services, doctors generally can also drive up income. But a third factor is American culture, particularly the common desire

for the latest and most technologically sophisticated test and treatment, combined with a desire to have that test and treatment as soon as possible.

The cultural preference for high tech services (that help sick people recover) over prevention and public health (to keep them from getting sick) is not, of course, a uniquely American phenomenon. As national income increases, so too does a national desire for the latest biomedical procedures. That said, however, this cultural preference is especially strong in the United States, where any effort to even consider the cost of a particular medical procedure is almost immediately labeled "rationing," an epithet that generates enormous political opposition. This then becomes yet another reason for the nation's institutional and acute care bias.

Finally, the interest groups that produce and deliver the latest technological advances (from pharmaceutical companies to academic medical centers) are politically influential. The public health community is not. It is thus an ongoing challenge to protect scarce public health funding, much less generate significant increases in appropriations.

Public Health in England and France: A Similar Bias Toward Curative Care

In the French and English contexts, a comparable bias appears toward curative medicine and access to health care and at the expense of consistent population-based health actions. Public health initiatives were marginalized in both countries after WWII while most policy efforts focused on improving health care infrastructures and access to medical care. As noted by many European experts, the eclipse of public health from the political agendas was paradoxical. Arguably, the development of more centralized

European welfare states in the aftermath of World War II provided a window of opportunity for developing stronger public health policies, but neither nation followed that route.

In England, the creation of the National Health Service (NHS) nationalized medical services and created a tax-based health system free at the point of services, but the NHS had quite limited responsibilities toward public health, which remained the responsibility of local authorities. Put simply, the NHS nationalized curative, acute, and individual care, while public health and social care remained a local responsibility. This contributed to the English bias in favor of curative medicine, at the expense of prevention and public health (Jones, 2009).

The low profile of British public health policies endured even after the 1974 reorganization of the NHS when public health was nominally integrated to the NHS, leaving only social care to the local level. This move, aimed at rationalizing health services and unifying the different facets of health policies, weakened the role of public health physicians and over time proved detrimental to public health, which lagged even further behind medical care. Subsequent reorganizations of the NHS continued to impact public health negatively. The creation of an internal market in 1991, separating purchasers of care and providers and introducing competition among health providers further fragmented responsibilities for public health, weakening both national coordination and the public health doctors (Scally, 1996). Furthermore, the 1990s conservative reforms introduced cuts in public health budgets, along with more demands for efficiency, which together proved quite problematic for the public health community.

In France, public health was also eclipsed by questions of access to care (Loriol, 2002; Steffen, 2000). But national state action in the realm of medicine and health insurance was more contested than in England, mirroring [to a lesser extent] the resistance to public action existing in the US. First of all, the creation of the social insurance institutions in 1945 and the sickness funds (non for profit occupational health insurance whose governance was left to the social partners, employers and employees unions) further decreased an already contested legitimacy of the government to intervene in health policy (Tabuteau, 2016), Secondly, public health also faced strong ideological and professional resistance linked to the tradition of liberal medicine in the French health care system (Hassenteufel, 1997). Public health initiatives were continuously opposed by the medical profession, in the name of their professional autonomy and the protection of the patient- doctor relationship. Resistance of medical professions diminished the scope of public health, reduced to interventions targeted on specific conditions (cancer prevention, alcoholism reduction, mental health) (Tabuteau, 2016).

With the creation of the *Securite sociale* in 1945, individual doctors maintained private practices and considered prevention in their remit, strengthening the biomedical approach to public health as a main policy orientation. While public health structures emerged, such as "occupational medicine", "school medicine," and "service of children and maternal protection" (PMI), these different centers were poorly integrated with the dominant liberal medicine. Qualified as "poor medicine for the poor" (Loriol, 2002), medical teams in PMI or occupational doctors did not enjoy, for instance, the right to treat and prescribe. Post-WWII public health in France has been secondary (Loriol,

2002, Morelle, 1996), poorly promoted, insufficiently coordinated, insufficiently remunerated, insufficiently incentivized, and insufficiently taught (Loncle, 2009).

A New Public Health: The Window of Opportunity

Improved access to medical care, seemingly endless technological progresses, and widespread eradication of much of the infectious diseases of the past, all contributed to the eclipse of public health initiatives in Western countries. However, from the 1980s on, more voices began to question the long-term viability of the current biomedical model. Highlighting the potential dangers of a minimal focus on prevention, and the rapid and supposedly unsustainable growth of health expenditures of a hospital-centered care system, increased voices began to make the case for more investment in public health. There emerged renewed attention to individual behaviors (such as unhealthy eating habits, excessive alcohol use, and smoking), along with the societal factors that encourage such behaviors (food deserts, segregated housing patterns, and inadequate economic opportunity). There were soon calls for a "new public health," though advocates differed on the merits of focusing on individual behaviors versus social conditions.

This rebirth of public health, creating a window of opportunity for public health, is visible in the three countries, arguably with the US leading the way. Back in 1988, for example, the IOM issued its blistering report on the poor condition of the US public health system. Since that time, however, the US public health community has achieved some surprising successes. Anti-tobacco initiatives have led to reduced smoking rates. Highway safety campaigns (from lower speed limits to anti-drunk driving initiatives)

have reduced highway fatalities. Fluoridated water is required in much of the country. There are numerous mandatory vaccinations programs (and the anti-vaccination movement remains small). There are regular health promotion campaigns that focus on healthy eating and physical activity, while also promoting community gardens and population based obesity prevention initiatives. There are new schools of public health springing up all over the country, and there is a new generation of active, engaged and highly-skilled public health professionals.

There also is an increased focus in all sectors of the US health system on "population health" and "population health management." Hospitals and other health care providers are increasingly put at financial risk for the cost and quality of care delivered to large "populations." Behavioral economists are turning their attention to efforts to "nudge" targeted populations to improve their health behaviors. Public health practitioners are themselves looking to new technologies (such as wearable devices) to generate "big data" that can enable population-based predictive analytics. There are more sophisticated efforts to analyze the return on investment of alternative population based strategies.

As in the US, the 1990s were also in England and in France a moment of potential rebirth of public health, with the release of numerous reports, commissions and policy changes, all designed to encourage a more individualized approach to population health, targeted on harmful behaviors, aimed at bringing more balance between acute care and prevention.

In England, the new era began with two white papers, both of which emphasized the need to invest in health promotion (*Promoting Better Health*, DoH, 1987 and *The*

Health of the Nation DoH, 1992). But these reports were largely symbolic and aspirational, setting targets for health improvement in areas such as cardiovascular diseases, cancers, mental health, but not resulting in additional funding (Webster, 1996, Watterson, 2003). The New Labour era (1997-2008) added attention to environmental and social variables (health inequalities), largely absent from the previous conservative government approach, but here again little substantive change followed.

By the late 1990s, however, the drumbeat of policy papers calling for an increased focus on prevention and public health eventually translated into a new approach, under which public health policy largely reverted away from the NHS and back to local authorities, who would presumably better integrate social and population health. Nonetheless, even with this renewed commitment, which included a goal of transforming the NHS from a "sickness service" to a "health improvement service" (Wanless, 2004), the policy initiatives developed by the Labour government have had limited success (Exworthy et al. 2002), as the acute care provided by the NHS continues to capture most of policy attention at the expense of public health interventions. This trend continues today, despite regular changes in the organization of care delivered by the NHS, ranging from autonomous hospital foundation trusts, the readjustments of the internal market, and the increase in quality regulation and clinical governance.

In this context, it is hardly surprising that cross-national comparisons document that the British continue to score poorly on a variety of public health metrics, including harmful drinking, smoking, and prevention more generally. Indeed, while Marmot argues that 40 percent of the nation's burden of disease could be prevented through action on the determinants of avoidable chronic conditions, and while the NHS England five-

year plan issued in 2014 calls for a "radical upgrade in prevention and public health," a recent report from the House of Lords health committee (House of Lords, 2017) characterized the nations efforts as "frustratingly low" and "chronically underfunded." Moreover, public health funding continues to be cut, not increased, contradicting the political declarations emphasizing increased efforts on public health. According to the Nuffield trust, in 2014, when only 5.3% of the NHS budget were devoted to prevention and public health, the government implemented a 7% cut in public health budgets and a 4% cut per year to the local authorities' public health budget. The committee noted "evidence of the type of shortsighted, compartmentalized thinking that seems to prevail across health policy."

In France, a similar reintroduction of public health onto the national agenda is visible from the 1990s on, following a series of sanitary crises, such as the contaminated blood scandal. Public health gained additional prominence through the notion of *securite sanitaire*, leading to the creation of several new health agencies, increasing disease surveillance (INVS), monitoring the quality of care (ANSES then HAS), and promoting health education (the national institute for health education and promotion - INPES) created in 2002 (Benamouzig, Besançon, 2005)

As in England, a certain legislative effervescence in the 2000s aimed at reinforcing public health as a priority in health policies. The public health law of 2004 represented an important step, by setting up a policy framework and objectives over several years (Loncle, 2009). The law created regulatory agencies, alert and reporting systems, and made the evaluation of existing programs more systematic. It represented an attempt to deeply renovate the role of the central state in public health, to centralize

and reduce fragmentation of initiatives, and to consolidate existing prevention policies and initiatives aimed at diminishing social and territorial inequalities.

Nonetheless, while the 2004 law defined 100 prevention priorities, no specific budget was appropriated, and the law is vague with regard to who is responsible for what. Enduring fragmentation of responsibilities between the ministry of health, the sickness funds and the regions led to implementation problems and general lack of data and evaluation of the effectiveness of existing programs. The results are mixed at best: improved metrics with regard to tobacco use and child obesity, but less success with reducing harmful alcohol use and adult obesity.

The nation's most recent health law (the 2016 health system modernization act)[2] contains measures aimed at improving access to care, rationalizing patients' pathways and improving public health and prevention. With regard to prevention and public health, the law thought to reinforce the coordination between hospitals, liberal medicine, social services and regional health agencies around public health priorities. The regional health agencies also have increased powers to develop elaborate regional health plans according to local health needs. At the central level, the fragmentation of responsibilities has been addressed by merging three public health agencies (the INPES, the INVS and the EPRUS) into one single agency *Santé Publique France* (Public Health France) on the model of Public Health England, with missions of prevention, promotion and education and crisis management, centralizing epidemiological knowledge and prevention. While representing an important step into the consolidation of public health expertise, critics regret that the new structure remains underfunded and understaffed.

[2] LOI n° 2016-41 du 26 janvier 2016 de modernisation de notre système de santé

Taking Advantage of the Window of Opportunity: Why the US?

The US system of public health fares rather well when compared to other western nations. This conclusion is perhaps surprising, as one would expect a few social and political factors distinctive to the US system presumably making its public health politics even more difficult. After all, there is in the US an ongoing backlash against government, a distrust of science, and a perception among many that government is simultaneously inept and dangerous. This trend is particularly apparent when "nanny state" politicians impose rules (from motorcycle helmets to smoking bans) that interfere with Americans beloved individual liberty. Moreover, European's with their more centralized social welfare system arguably have a greater appreciation and acceptance of government regulation, oversight, and laws aimed at protecting the public good.

What then explains this public health window of opportunity (in an era in which traditional medical care still dominates)? Why might the US score higher on a public health scorecard than many of its high-income peers? Three factors seem plausible: the American brand of public health moralism, the power of the public health policy entrepreneur, and emerging trends in the American medical care delivery system.

Public Health Moralism?

The most controversial issues in public health inevitably involve government interference in presumably private behavior. Given America's liberal roots, the public health proponent typically argues that unregulated private behavior can have negative public consequences, on both the health and the budget of the larger community. The

motorcyclist without a helmet could well become the paraplegic on Medicaid. The chain smoker, soda drinker, and substance abuser also are more likely to incur high lifetime health costs, largely paid for with public dollars. At the same time, there also is an increased focus on the population health consequences of certain individual behaviors. By focusing on the impact of second-hand smoke, for example, the public health advocate both stigmatizes the smoker, and also persuades that efforts to regulate or tax cigarette use is necessary for the overall public good.

Those opposed to these regulatory interventions often ground their ire in their own moral reprimand. The obese are the victims of their personal choices; their failure to eat healthy food and/or engage in regular exercise is their own fault. Perhaps a mild public education campaign is justified ("just say no" to sugary drinks), combined with a hope the target audience changes behavior. But the addict presumably will have no one to blame but himself if he cannot resist the lure of the drug (or the drink, cigarette, or can of Pepsi). And the effort to use the public "police power" to change behavior, perhaps by imposing a cap on the size of the "Big Gulp" soda, allegedly moves us toward a "nanny state" in which "big brother" interferes with our individual liberty.

Over the past few decades, however, public health advocates have become increasingly successful in turning the moral arguments in their favor. The cigarette smoker, the drunk driver, and even the obese are increasingly stigmatized, thereby justifying public health interventions. Moreover, the moral judiciary sometime shifts its binoculars away from the individual and toward a corporate villain. The tobacco industry was vilified for lying about the dangers of cigarettes. The food and soda industries are accused of marketing to children, who understandably fall prey to their manipulative

strategies. Car manufacturers and coal companies are cited for deliberate deceit and actions that are harmful to the public good.

The public health debate often thus turns into competing moral claims. This is not a uniquely American phenomenon. But moral arguments can carry greater weight in the US than in many of its peer nations. The power of the moral stigma and the focus on the corporate villain are both factors that have contributed to cuts in the percentage of smokers as well as drunk drivers. To be sure, moral suasion alone is usually not enough: cigarette taxes are perhaps they key driver in lower smoking rates in the US, and jail sentences have had a similar impact on drinking and driving. That said, however, moralism plays an exceptionally large role in every aspect of American public health policy.

Policy Entrepreneurship?

Political scientists have long debated whether there is a theory that can offer a useful and generalizable lens into how policy shapes politics (as opposed to the other way around). James Q. Wilson suggested one such approach: look at whether the presumed costs and benefits of the proposed policy are concentrated on particular groups or diffused among large populations. More specifically, for example, if the costs and benefits are both concentrated on discrete groups, the politics likely will be an interest-group battle between those two groups. But if the costs are concentrated on a discrete group and the benefits are dispersed among a wide population, then the proposal is likely to be defeated, <u>unless</u> there is a policy entrepreneur who can raise the public visibility of

the issue (or a crisis or disaster that does the same thing), such that large segments of the population become more politically engaged.

Public health policy proposals often fit into the latter category: the costs are concentrated (say on pollution emitting coal mines) but the benefits are widely dispersed (say the general public). Sometimes a catastrophic event can focus public attention on the need for reform. The nuclear plant disasters at Three Mile Island and Chernobyl are examples. But there also are important examples of policy entrepreneurs changing the changing public health politics. Rachel Carson's book "Silent Spring" encouraged and energized the environmental movement. Ralph Nader's book "Dangerous at Any Speed" had a similar impact on car safety regulations. But it doesn't always take a book by an academic or activist. Candy Lightner's daughter was killed by a drunk driver, and her outrage over the lenient criminal penalties in such cases led to the creation of the group "mothers against drunk driving," (Lerner, 2011), and to both changes in criminal law as well as new public health campaigns (always have a designated driver).

Michael Bloomberg, the former Mayor of New York City, used his elected position to serve as a public sector public health entrepreneur. Under his leadership, New York City adopted a "health in all policies" approach, under which every city agency was instructed to consider the public health implications of their work, be they in charge of schools, the police, or housing. The city also enacted a host of new public health measures, and tried (and failed) to go even further (such as with the unsuccessful effort to ban the sale of sugary drinks larger than sixteen ounces by convenience stores and fast food outlets. The courts eventually struck down the ban, saying the Mayor had failed to get needed approval from the City Council. But Bloomberg continues to push (and fund)

efforts to dramatically cut soda drinking, and one result is a recent wave of cities (starting with Philadelphia) enacting soda taxes, that have significantly cut soda sales.

At the same time, however, this variable seems equally relevant in other political contexts, and seems less persuasive in explaining why the US might outperform its European public health counterparts. Indeed, other nations were developing "health-in-all-policies strategies (and similar initiatives, such as "health impact assessments") long before Michael Bloomberg entered politics. Put simply, the need for public health entrepreneurship seems to be a common theme, as opposed to a distinctly American advantage.

The Transforming Medical Care System?

The US health care system is in the midst of a significant transformation. The system is consolidating, and the effort to get "bigger" is accompanied by an attempt to develop "integrated delivery systems" in which previously siloed sectors (the hospital, community clinic, office-based physician) all become part of a single organization. These new integrated delivery systems have access to data about their utilization patterns and costs that far exceed what has long been available. Meanwhile, payers are seeking to move away from fee-for-service payment and towards so-called "value-based purchasing," and in so doing are experimenting with efforts to put groups of providers at financial risk for the cost and quality received by defined populations.

These developments present a window of opportunity for the public health community. There already is a growing interest in so-called "population health management," the effort to use data, incentives, and management tools to provide

improved and targeted population-based preventive care. There are numerous efforts, for example, to use community needs assessment data to better target preventive services within particular community. To be sure, most of these efforts are in their infancy, and the practice may not achieve the promise. For example, New York State received more than $8 billion in supplemental federal Medicaid funds as part of an effort to transform and improve the health delivery system for low-income New Yorkers. This effort will succeed only if health systems can develop novel strategies to improve population health metrics (while also reducing costs).

It is (far) too soon to tell if the trend toward "population health management" is a passing fad or a meaningful change. Moreover, it is too new a trend to explain any prior public health success. That said, however, it is clear that there is a new commitment to these efforts, by both public and private payers, and that this experiment offers an important opportunity for the public health community.

The English *National Health System* and the French social insurance-based system, while very different both from each other and from the US systems of care, share many similarities with regard to public health policy and practice. First, as in the US, public health in England and France is far from a priority on the political agenda, lagging behind more prominent acute care and access policies. Moreover, and perhaps more surprisingly, both England and France have fragmented and locally dominated public health systems, despite their more general centralized traditions, and despite their long history of centralized health care programs. This fragmentation and local control endures despite recent attempts at comprehensively reforming and centralizing the public health

system. It also helps to explain why the public health infrastructure and influence remains weak.

The Politics of Public Health: Some Cross-National Lessons

The politics of public health has common cross-national features, starting with the lack of a strongly mobilized constituency in its favor, in contrast to the traditional medical care system with its powerful and influential interests. Indeed, public health is politically invisible until a crisis (tainted food, an Ebola epidemic, a devastating hurricane) and it typically recedes from public view once the crisis ends. Making the job of the public health advocates even harder is that it is difficult to show clear evidence of a return on investment for the population health dollar. It also is human nature to identify more immediately with individual misfortune in persons who look like "us" than to bad news about population based threats that seem distant and hard to measure (such as the impact of climate change). And as nations become more economically secure, there evolves as well a cultural preference for the latest bio-medical procedures (that help sick people recover) over prevention and public health (to keep them from getting sick). For all of these reasons, high-income countries spend the vast majority of their health care dollar on acute and high-tech care, and funding for public health and prevention is both minimal and endlessly vulnerable to cost-cutting pressure.

In addition to these common cross-national themes, there are factors distinctive to the US system that presumably make its public health politics even more difficult. After all, there is in the US an ongoing backlash against government, a distrust of science, and a perception among many that government is simultaneously inept and dangerous. This

trend is particular apparent when "nanny state" politicians impose rules (from motorcycle helmets to smoking bans) that interfere with Americans beloved individual liberty. Moreover, European's with their centralized social welfare systems arguably have a greater appreciation and acceptance of government regulation, oversight, and laws aimed at protecting the public good.

Surprisingly, however, the US spends more on public health than does its English and French counterparts, while also outperforming both on several public health metrics. While hardly a public health leader, the US also is not a public health laggard.

What explains this unexpected outcome? The argument here is three-fold. First, the US federal government has had a longer and deeper engagement in public health policy than have their European counterparts, a surprise given the more centralized nature of European social welfare systems. It turns out that public health in England and France is even more locally driven than the system here in the US. Second, US public health advocates have become increasingly successful in turning public health morality in their favor, stigmatizing the cigarette smoker, the drunk driver, and the obese (thus justifying public sector interventions) while also framing the tobacco industry and other industrial giants as corporate villains. And these moral arguments are often more persuasive in the US than in its cross-national counterparts. Finally, the US health system is slowly transforming, evolving into large (and somewhat integrated) delivery systems, that increasingly are at financial risk for the cost and quality of care received by defined populations. The resilience and impact of this trend is unclear, as is its impact on public health politics. That said, however, it is an important variable to track going forward.

That the US public health system fares well in a cross-national comparison may be a surprise, but it also is at best a pyrrhic victory: each of the nations discussed in this paper would do well to dramatically increase their commitment and spending on public health and prevention. The argument for doing so is clear and compelling, and set forth persuasively in numerous white papers, policy memos, and academic treatises. The inevitable obstacle however, is politics: interest groups dynamics, cultural concerns, and the political invisibility of much of the public health enterprise. Only by overcoming these obstacles, however, will we move toward better, fairer and more effective ways of encouraging healthier societies.

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