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Is Health Politics Different?

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Abstract: The aging of the global population, combined with changes in technology and cultural understandings of disease and the body, have thrust discussion and contestation over health into the center of local, national and global politics. In this essay I ask a deceptively simple question: whether the politics of health is “different” from the politics of other policy domains. On a number of dimensions, I conclude that health politics is in fact different. Voters and politicians in the developed world appear more likely to accept redistributive claims with respect to health than they are with other policy areas. Nations vary more widely in spending on other functions of government and policy than they do on health. Moral claims made about health are more likely to attach to its politics than to the politics of environment, labor, finance and energy. More than these other realms, health politics encompasses issues regarding identity, the human body and other personal matters that endow the health arena with greater significance. Bureaucratic agencies of state are more involved with provision and regulation of health politics than in other areas, and the science-related nature of state expertise allows science and medicine itself to be sculpted in deeply political ways. The essay concludes with implications for how political scientists should approach cross-policy generalizations with caution, and with a call for greater engagement with health politics – to do for political science what health economics, the history of medicine and medical sociology have done for other social science disciplines.

The flourishing of life has engendered a new politics of health.

The year 2010 finds global human population at approximately 6.7 billion, up from 2.5 billion in 1950 and 1.7 billion in 1900. The median life expectancy in the United States rose from 69.8 in 1960 to 78.4 in 2008, and in many other countries (Australia, Canada, most countries in Western Europe, New Zealand, Singapore, and South Korea) life expectancy at birth is appreciably higher than in the U.S. The stunning growth of human population in recent centuries is due primarily not to higher reproductive rates but to higher life expectancy, and human longevity in turn is a function less of high-technology medical advances and more of improvements in nutrition, public health policies such as vaccination and infrastructure, and improvements in communicable disease treatment (World Bank 2010).

For several reasons, human longevity has infused health politics with a significance that few other realms of contestation can match. The lengthening of the human life span has created unprecedented expectations about how long a person can live, about how long they ought to live, and about the quality of living while alive. Contemporary human societies tend to regard the death of a young adult or middle-aged adult as a greater tragedy than past societies did, not least because we would today have expected that adult to have lived longer. And there is evidence that human societies attach greater expectations of equality and equity to these health chances than they do to other realms of modern life (finance, education, employment) where unequal stakes prevail. These expectations and variations in them across citizens and societies occasion deep debates over whether and how societies ought to structure access to health services. Disparities in access to health services and treatments are widely understood to shape vast inequalities in life chances.

So too, with ingrained assumptions about the quantity of life, human societies have begun to attach greater meaning to its quality. And the meaning of “quality of life” is deeply tied up with human health. If we expect to live to eighty rather than to forty, we may care more about the free use of our limbs and human faculties. Long past the point when we no longer can or wish to procreate, we may care about the quality of our sexual functioning. We may care more about long-term mental health and cognitive functioning, our moods and our memories.

Yet the most profound link between human longevity and health politics stems from a deep material irony. The lengthening of human life means, in some basic sense, that humans spend more time being sick. This relation holds in some absolute sense; we live longer and thus have more chance to experience illnesses such as cancer. Yet this pattern also holds in a deeply interpretive sense; as expectations of health and functioning have risen, conditions that detract even moderately from a sense of optimal human functioning have become interpreted as diseases. Many common aspects of the human condition have become "medicalized" in this way, in part from science and in part from the profit motive (Greene 2007).

Two brute facts of the "longer life, more sickness" relationship have transformed health politics. First, in the past century there has been a rise in the incidence and politics of chronic disease. Chronic disease envelops those medical conditions that do not pass like influenza or a broken nose but persist for years or decades: high blood pressure, arrhythmia, rheumatic arthritis, clinical depression, Alzheimer's disease. Chronic disease has generated vast markets of technology and service for dealing with it, even when (perhaps especially when) there is no cure for the disease state itself. U.S. and global expenditure on health has skyrocketed in the past half century, with American public expenditure on health now amounting to nearly double its aggregate defense expenditures (already extremely high by comparison with other nations), while three-to-one to five-to-one ratios prevail for health-to-defense expenditures in Western European nations such as France, Germany and the United Kingdom (among OECD countries, only Israel and South Korea spend marginally more on defense than they do on health as societies).

The second brute fact concerns caregiving. Caregiving – the acts of one human or humans providing health services for another – counts among among the oldest of human relationships. Yet human longevity and the changing nature of sickness have transformed these interactions. Caregiving patterns have been rearranged in both institutions and markets, in ways that are politically and ethically relevant (Kleinman 2008). In some cases, kinship, partnership and other social networks are transformed as the members of these networks take on new forms of labor. In other cases, the burden of caregiving is greater than family or kinship/partnership networks can efficiently bear, and markets for more complex care relationships surface, or care is foregone. Institutions provide care and represent sources of employment and income. These include nursing homes, eldercare facilities, long-term care facilities and other institutions, all of them well represented in democratic political systems. With these institutions and these human demands, the question of long-term care insurance in the United States and other countries has arisen as another central policy issue.

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Health, then, has become a defining facet of modern life, and its politics all the more vital. Yet is health politics different?

An understanding of any such difference requires an answer to the question: different from what? I have in mind distinctions from distributive politics, economic politics, class politics, religious politics or identity politics in other forms. My question might be restated as follows: while it is undoubted that we should study health politics for its importance, will it conform easily to the models and understandings of politics that we already have in political science?

In this essay I entertain the possibility that health politics is in fact different from many of the patterns that political scientists and other social scientists study. By different I do not mean unique. There are deep similarities between health politics and these other arenas of politics – pluralist policies, distributive policies and ideological strife over the role of government in health services provision and various social and cultural issues entangled in the meaning of health and public health. Yet as I hope to show, the differences are tangible, and focusing on these differences for health policy is especially useful for three reasons: (a) the importance of health policy as an area; (b) the fact that these differences in the health area have not received the exploration they deserve; and (c) the way in which the differences suggest important ways in which we change how we think about the standard models of politics.[1] I proceed speculatively because political scientists have not yet catalogued or established differences between health politics and other arenas. Compared to the study of politics in many other realms (labor, environmental), the study of health politics is in its infancy. As a set of plausible hypotheses, then, health politics is different in at least three dimensions.

1. There persist widely held **notions and norms of equality** in access to health services, due not least from health's status as a constitutive expression and measure of well-being. These beliefs have vast consequences for public policy, ranging from the provision of health insurance to funding for global health initiatives to the form of regulation of safety regarding health.

2. Health is intimately related to **human identity** in ways that echo class politics but elude simple binary and hierarchical relations. Class and economic politics often divides the wealthy from the less wealthy, or the owners of capital from labor. Yet the primary divides in health politics are not starkly and directly defined between those who are more or less healthy, or between those who provide health services and those who employ them. While there are wide geographic differences in health outcomes and institutions both globally and regionally, health politics does not often give rise to the kind of sectionalist politics associated with trade and industrial issues.

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[1] I thank an anonymous reviewer for this point.

There are instead wealth and ideological differences associated with the proper role of the state in health provision and the appropriate generosity of health benefits. There are vast disparities based upon the particular kind of disease afflicting an individual, as in the United States those afflicted with breast cancer have in recent decades benefitted from political organization and cultural legitimacy far greater than that experienced by sufferers of hundreds of other diseases. The differences go further still. Whereas humans often organize on the basis of claimed identities, many health conditions are those that humans would prefer to keep private – diseases that are sexually transmitted, that entail stigmatized conditions (such as obesity or a chronic infectious illness), and mental health disorders. In this way, the public organization of disease contrasts with its private experience.

3. **Technology and expertise** combine in powerful ways to differentiate health politics. Much if not most health care is delivered, organized and regulated by professionally or societally sanctioned experts. This pattern is as often true in developing, industrializing nations (consider India and its healers organized and legitimated in the Ayurvedic, Siddha and Unani traditions) as in advanced industrialized countries. Organized in professions, guilds and other forms, these experts bear significant legal and cultural authority, and they are often remunerated at levels that are high in the income distribution of their societies. So, too, health technology creates fields of expertise, which in turn create and harness new forms of technology. This process of specialization undermines old orders, and it creates specific industrial interests, such as the biotechnical and medical device research enterprises. In the realm of health, technology meets concrete human meaning in the most tangible of ways. Scientific research has permitted for new and distinctive claims about identity; notice the novel and unpredictable way that evidence

for possible genetic bases of homosexual attraction has become an important source of cultural as well as scientific legitimation of gay and lesbian identities in advanced democracies.

In following discussion, I examine four dimensions of health politics: (1) cross-national comparisons and similarities, especially the politics of insurance and access, (2) the role of regulation and the state (in areas concerning access and insurance, and in areas separate from these realms), (3) newly emergent "global health" politics, and (4) the politics of disease. In each of these dimensions, health politics differs from other realms of politics in ways that point to important research agendas for political scientists.

1. Health Politics and Insurance in Comparison

Health forms a vital (some would say the fundamental) component of human well-being. A person or group with vast landed, material or financial wealth can suffer greatly by virtue of illness. To the extent that people equate health with well-being, health welfare becomes partially internal, experienced tangibly in body, in mind and (for many) in soul. By contrast, well-being in other dimensions is often external (wealth) and/or attributed (status). To be sure, wealth, health and status are deeply correlated – those individuals and communities of higher income and status enjoy, on average, superior health. Yet wide variation in health experiences within and across income and class groups remains. Health may not be independent of wealth and status, yet it is far from reducible to these dimensions of welfare.

Beyond its personal dimension as a form of human experience, many observers and scholars argue or assume that some minimal health is necessary for human functioning in other realms such as citizenship, labor, education, consumption, reproduction, leisure and spirituality (Sen 1999, Daniels 2001; Nussbaum 2002, 2006; Sackett and Torrance 1978). The idea animating these arguments is not that societies can or should aim at equality in health, but that they should aim for a kind of equal opportunity for health (Jacobs and Morone 2005). These philosophical claims often accompany broad policy recommendations, such as calls for universal provision of health care by governments (by those societies or individuals believing in a more active role for government in insurance or care provision, such as the National Health Service in the United kingdom, or proponents of a "public option" in the United States (Hacker 2009)), or in more subsidization of individual access (by those believing in a less active role for government in this area; Herzlinger 2004). Empirically, these philosophical claims result in particular attention to disparities in health treatment or health access; given a cancer diagnosis, a heart attack, or car accident, do different individuals in different circumstances face different patterns of treatment (e.g., Shavers and Brown 2002)? Political scientists could, but currently do not, occupy an important a role in examining these disparities.

The claims made about primacy of access to health services are moral, social and political. An instructive comparison emerges when we compare the case of insuring health access with that of insuring other features of human welfare. If an individual is born to a poor family with a severe disadvantage in education or wealth, many advanced industrial societies take measures (of varying generosity) to remediate these disadvantages, including provision of education, nutrition and family support. Except for the limited case of education, however, these measures fall far short of explicit or implicit attempts to equalize access. Yet for individuals born with disabilities or stricken by diseases, whether poor or not, there is greater consensus in advanced industrialized societies on the proposition that insurance ought to be available, including with subsidization or redistribution. There exists no such breadth of government provisions for equality of access to loans and capital; only education would seem to rival health in this domain, and even here there are sharply distinct systems across national contexts. In some of the very countries that have universal health insurance (France and Germany, for example), there exist state and market structures that implicitly and explicitly assign people by talent or educational attainment to vocational and scholarly tracks from a rather early age. In other words, *there exist forms of embedded and planned inequality in education and vocational training in those very countries where there is formal and structural equality in health access* (with the United Kingdom providing a clear example). So too, many forms of social insurance in advanced industrialized countries are tied to work in ways that render citizens' benefits dependent upon their prior working and earning history (Social Security in the United States; European examples). Yet the health insurance systems of advanced democracies and developing nations alike tend, where feasible, *not* to condition public health benefits upon previous earnings or work history. These and other countries treat health differently from other areas of social policy.

In advanced, industrialized democracies, the national state often guarantees health insurance, through what is known as a *single-payer system* (Canada, the United Kingdom), in which there is universal access and one state purchaser of health services; through *universal health insurance with partial or full proprietary provision* (France, Germany, the Netherlands); or through *subsidization and regulation of private markets* (Switzerland, United States). Comparative and institutionalist scholars of health insurance regimes commonly examine cross-national differences in at least three variables:

- universality of coverage (public or private) [often measured quantitatively by the % citizens with insurance or institutionalized access to care, and relatedly by what share of health expenditures are out-of-pocket for citizens];
- the fraction of insured population covered by a government program [often measured quantitatively by the % of citizens, or relatedly by the percentage of national health expenditures that are public];
- the total and administrative costs of the health care system [often measured quantitatively by per capita health expenditures and their growth, often controlling for demographic or quality of care characteristics]

The archetypal examples of national health insurance (high on the first two dimensions, lower on the third) occur in western Europe, where it is widely perceived that systems of health insurance deliver greater affordability and formal access to care, though perhaps with fewer of the technological advances that prevail in more costly systems such as the United States.[2] The standard international comparisons point to the expansive and generous character of Australian, British, Canadian, French and German systems and the relatively limited character of American arrangements (Starr 1982; Immergut 1992; Skocpol 1992). Most comparative historical scholars examining health insurance institutions in advanced industrial democracies have repeated a version of Werner Sombart's question about socialism: why is there no universal health insurance in the United States? There are claims that American voters and politicians are unwilling to accept these kinds of policies, such that the apparent historical distinctiveness of the U.S. rests in its political culture (see Hacker 1998, 62-63, for a review and rebuttal of these claims). Other literature points to the comparative strength of organized medicine and other interest groups in the United States (Immergut 1992, Quadagno 2005), or to the strongly incrementalist character of American policymaking institutions, with separated powers and veto points, arcane legislative procedures such as the filibuster, and congressional committee jurisdictions (Steinmo and Watts 1995).

In a series of well-known studies, Hacker (1998, 2002) examined these cross-national differences and found them to be historically contingent. To begin with, Hacker re-examined the portrait of American generosity and, in the 1990s, found it too simple. There was nothing of "American exceptionalism" in terms of the fraction of wealth or income spent on health or health insurance. The U.S. differed appreciably from other advanced democracies, Hacker found, not in the amount of GDP devoted to health insurance but in the mode of financing and delivery: a system based upon private

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[2] Such comparisons must now be reformulated, at least partially and temporarily, in light of the passage of the Patient Protection and Affordable Care Act of 2009 (Jacobs and Skocpol 2010). Here I review some of the earlier literature and I treat the PPACA separately below.

insurance companies, largely financed through employers for those of working age, without universal access, where vulnerable and elderly populations were covered with special (Medicare) or patchwork (Medicaid) programs. The American case was different less in scope than in institutional form. Comparing the U.S. to Britain and Canada, Hacker (1998) argued further that the dominant cross-national differences among these three English-speaking countries lay neither in the strength of medical lobbies nor, at least primarily, in the national legislative or policymaking institutions. The critical difference was the timing of reforms, a process by which health insurance policies, once created, fed back into politics. The British and Canadian governments acted to create their national insurance systems during junctures (the Progressive Era and the immediate post-WWII period) when private insurance industries were non-existent or in their infancy. State insurance programs thus occupied a historical insurance "niche" before private actors did. By contrast, a series of failure of American health insurance reform from the 1910s (Theodore Roosevelt's attempt) to the 1940s (Truman's attempt) through the 1960s (the diversion of universalist energies into Medicare) allowed private health insurance companies to dominate the market and stand as a formidable obstacle to reform. Even important insurance advances such as Medicare confirmed and reinforced the patchwork dynamics of the American case, as senior citizens' lobbies actively opposed the potential dilution of their advantageous benefits by expanding them to a broader population (Jacobs 2007). Policies – both their successes and their failures – shaped politics by creating and foreclosing opportunities and lobbies.

More generally, Hacker (1998: 85; 2002) recommends comparing national health insurance regimes, historically and cross-nationally, along at least three critical dimensions of explanatory difference. These are:

- The characteristics of the population initially covered under public coverage (e.g., universal access v. wage-earners v. elderly and disabled);

- Whether the expansion of access occurred before the expansion of capacity, and vice versa;
- The extent to which physician-controlled private plans developed (low in the United Kingdom, for instance, but quite high in the United States).

It is these three factors, Hacker argues, that explain the divergent systemic developments between Britain, Canada and the United States (1998), and the first two of these factors help to explain why health insurance in the late twentieth-century United States was characterized by private provision while social insurance was characterized largely by public provision.

Hacker's insights stand up well to the passage of time. Even with the passage and implementation of the Patient Protection and Affordable Care Act (PPACA) of 2010 – the national health reform act which promises to achieve near-universal coverage for Americans – many of the differential features of the American model have been preserved (Jacobs and Skocpol 2010). These include the private provision of health insurance (which not only remains but is enhanced by a government mandate that individuals purchase health insurance coverage), the lack of a universal system and the dominance of existing patchwork programs (much of the expansion of coverage to the poor comes through a large expansion of Medicaid, and Medicare's distinctive identity within the system remains). Recent changes to Medicare, including the advent of prescription drug coverage under its Part D enacted in 2002, represent a further gesture toward private provision, so much so that Medicare recipients are less likely to see their drug benefits as coming from the state (Morgan and Campbell 2011).

Table 1: Out-of-Pocket Expenditures for Health, 1980 and 2008, Selected Nations

	1980		2008	
	% of Health Payments OOP	Average OOP (in US$)	% of Health Payments OOP	Per capita OOP (in US$)
Australia*	15.3	$98	18.0	$605
Denmark	11.4	102	15.7	$489
Finland	18.4	105	19.4	583
France	12.8	85	7.4	273
Germany	10.3	100	13.0	487
New Zealand	10.4	52	13.9	372
Switzerland#	37.6	547	30.8	1424
United Kingdom	8.6	40	11.1	347
United States	23.4	256	12.1	912

Source: OECD Health Data ("Frequently Requested"); available at http://www.oecd.org/dataoecd/52/42/48304068.xls [accessed August 20, 2011]. Variables "OOP Payments, % health expenditure" and "OOP payments, per capita US$PPP". Comparisons are limited to European countries and Australia, New Zealand and U.S. due to availability of comparable historical data for early- to mid-1980s. * means 2007 data instead of 2008 data; # means 1985 data instead of 1980 data.

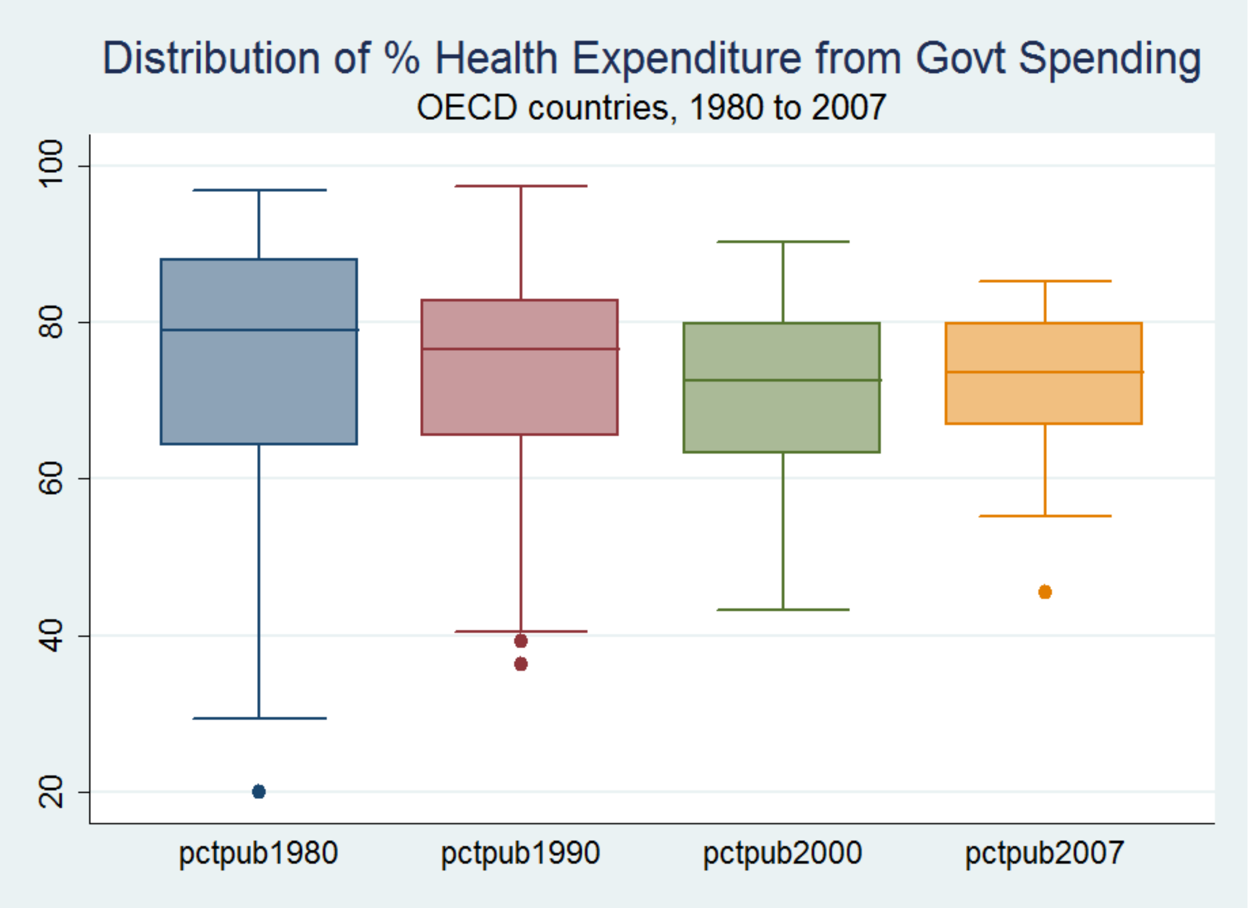
For purposes of understanding the comparative and historical dimensions of insurance, it is worth setting Hacker's insights in deeper cross-national and historical context. One significant development comes in the fact that, even before the passage of the PPACA of 2010, some features of the distinctiveness of the United States had been waning. Or, put differently, relevant features of cross-national systems have been converging in some important respects. For many years in the mid-twentieth century, the United States ranked quite high among advanced industrialized democracies in the share of health payments that its citizens made out of their own wallets (see Table 1; these differences were noted by many authors examining cross-national differences, for example Rodwin and and Sandier 1995). Yet in revealing ways, these differences have waned in recent decades. With the enactment and expansion of Medicare and Medicaid, as well as a corresponding (often subsidized) expansion of private health insurance, the share of health expenses paid out-of-pocket by American citizens declined significantly, and it now rests somewhat below the norm for countries tracked by the

Organisation for Economic Cooperation and Development (OECD). This share is a revealing, albeit highly imperfect, indicator of the kinds of income and security shocks that citizens incur from health. It is instructive, then, that the share of American health care dollars spent out-of-pocket dropped by nearly half from 1980 to 2008, going from 23.4 percent of expenditures at the beginning of this period to 12.1 percent of expenditures in 2008. Most other countries in a European and Australian sample saw a small increase in the percentage of spending out-of-pocket. In this respect, a larger share of Americans' health expenses has come from insurance over the past few decades.

What has not changed is the much higher average cost of health services in the United States, a difference that translates into much greater average expenditure for its citizens, both through insurance and out-of-pocket. Even though less than one in eight dollars spent on healthcare in the U.S. is out of pocket, the per-capita yearly payment was $912 in 2008, appreciably higher than all European countries save for Switzerland, which has long seen a much higher percentage of health spending out of pocket. Hence while there has been convergence in the technical reach of insurance over health spending, the real-dollar cost of health to Americans, direct and indirect, has risen appreciably, a fact that generates tremendous income and social insecurity (Warren and Tyagi 2007). A critical factor in this cost difference is the technology-intensive nature of American health care (Jacobs 1995; Cohen and Hanft 2004).

Looking across advanced industrialized democracies, there remains tremendous variation in the share of national resources devoted to health expenditures. The general share of national GDP taken up by health has increased, but the variance across countries, accounting for this growth, has not. In 2007, the fraction of GDP accounted for by health spending was lowest among OECD countries such as Israel (5.3%) and Mexico (5.6%), whereas in Western European and other advanced democratic countries it ranged from 8 to 11 percent of GDP, with the United States topping the list at 15.1 percent of GDP.

Yet as Hacker argued in his 2002 volume *The Divided Welfare State*, there remains significant variation among advanced industrial countries in *what percentage of their health expenditures is accounted for by government spending*. This ranges from 45.4 and 45.5 percent in Mexico and the United States to above 80 percent for Sweden (81.7%), Japan, the United Kingdom (82.0%), Iceland, Norway, Denmark and the Czech Republic (85.2%).



Yet in recent decades this index, too, has become less variable. Using OECD data from 1980 to 2007, Figure 1 displays "boxplots" of the variable "percentage of national health expenditure accounted for by government spending." For each year, the medial line (bolded) is the median value, and the solid box is the inter-quartile range (25th percentile to 75th percentile), while the ends of the stems are the 90th percentile range (5th percentile, 95th percentile). Outside of these are any outliers, represented as dots. It is easy to see the strong contraction in the distribution of the share of health spending attributable to governments; even though the United States and Mexico remain “low” outliers in more recent data, these countries have both recently enacted national health insurance reforms that may well bring them closer to global averages. In short, *nations have become to look more and more alike one another in the degree to which their health economies are characterized by public sector insurance*. This fact has been little noticed and represents an important research agenda for historical institutionalists (who may rightly disaggregate this convergence and find that it conceals several different mechanisms) and political economy specialists. And again, it marks the sphere of health politics as somewhat differentiated from other spheres; no such convergence has occurred for defense spending, for instance, or for changes in public sector spending in education (OECD 2009, 2011).

One reason for the convergence comes, again, from an examination of the cross-national data. Health spending as a share of national resources has been growing everywhere, and this process has accelerated the role of public sector provision. As Figure 2 shows, in those OECD countries where health spending has increased most strongly as a percentage of GDP in the last 20 years, there has been a corresponding above-average rise in the percentage of that health spending done by the government.[3] Yet this fact again leaves us without a mechanism: what factors have plausibly and demonstrably caused this *rise in public sector spending on health*, especially where health spending itself has grown?

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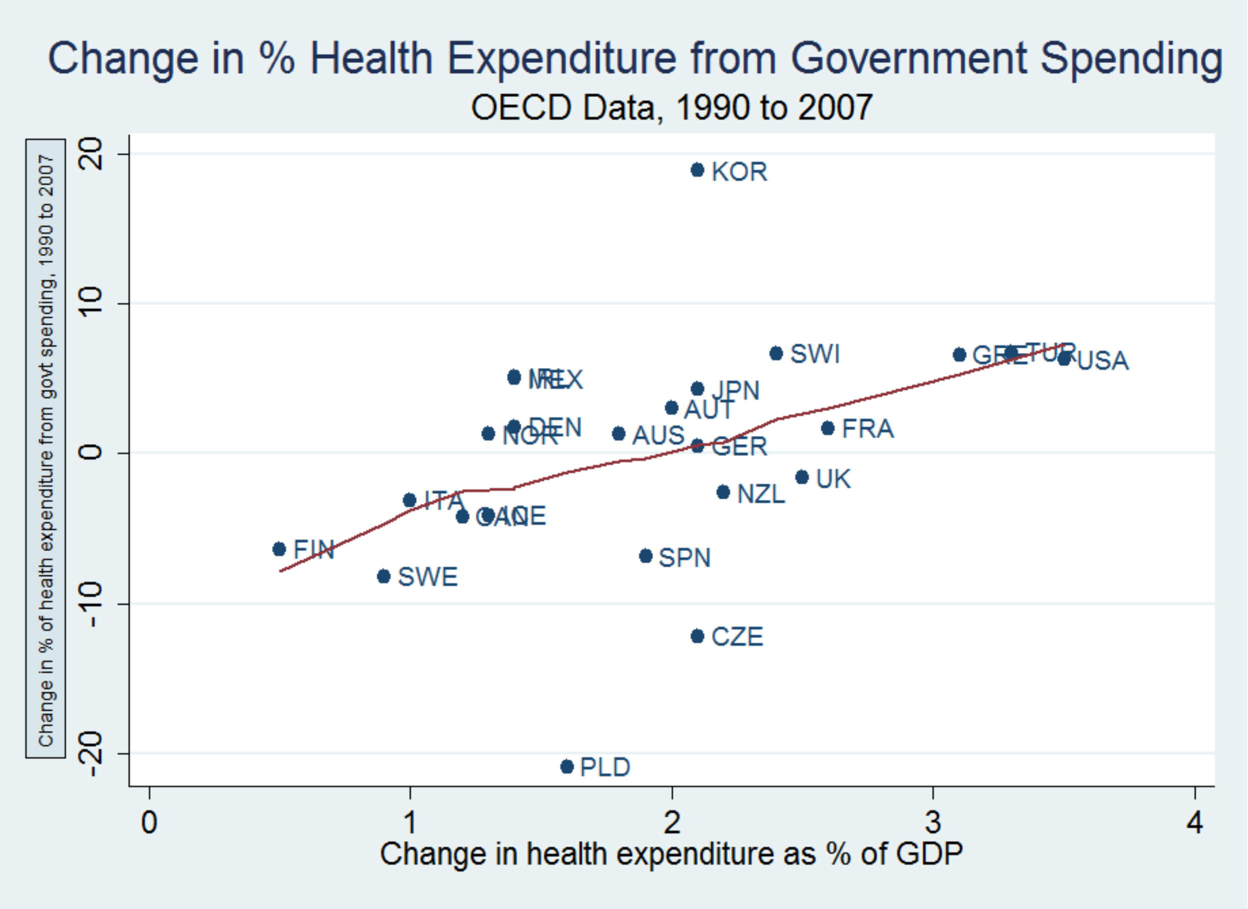
[3] Figure 2 shows the scatterplot of these two variables, along with a lowess regression line that is nearly linear. Regression results display an association similar to that observed in Figure 2. Of course the horizontal and vertical axes in this figure could easily be reversed.



Untangling the answers to these questions is not an easy enterprise, in part because the utilization of health services depends in part upon the willingness of the government to pay for, or subsidize, those services. But so too, the degree of government support will depend, at least in part, and subject to the contingencies of historical sequence and political economy, upon the aggregate demand for these services, which brings into play such factors as the aging of the population.

It is important, too, to recognize that what is often called the "European model" or the "social democratic" model of Europe conceals as much variation as it summarizes. It is true that in European countries there is greater effort at cost containment, including in historically liberal countries. So too, European citizens would appear to acknowledge the features of their systems, especially when compared to the United States. Large-scale surveys such as the Eurobarometer show that European citizens perceive much greater access and affordability for family physicians , and hospitals and much less for long-term care or nursing homes.[4] Yet in some of these nations, especially Switzerland, there is a considerable role played by private insurance organizations. In France, as well, scholars have observed an appreciable role played by a private and/or independent hospital sector.

Major change, of course, came in enactment of the Patient Protection and Affordable Care Act. In United States in 2009 and 2010, health reform came to be identified with partisan politics and the approval or disapproval of President Barack Obama. Despite having been watered down by significant political and ideological opposition, the PPCA Act stands to widen health insurance coverage by a vast margin in the United States, bringing 20 million uninsured under the protection of health insurance and reducing the uninsured rate to less than 10 percent of all American citizens (Jacobs and Skocpol 2010). At this writing, a central plank of the system, the so-called "individual mandate" whereby individual citizens are required to carry one or another form of health insurance or pay tax penalties, is under constitutional challenge, and conservative politicians have vowed to roll back part or all of the PPCA.

Once erected, national health regimes are not fixed in stone. Elected authorities often render institutional changes to these policies, and these changes arrive less incrementally and more often in critical junctures of legislation (Britain's National Insurance Act of 1911 or the National Health Service Act of 1946; Japan's National Health Insurance Law of 1922 and critical revisions in 1958 and 1973; Canada's National Medical Care Act of 1966; the enactment of Medicare and Medicaid in the Public Health Service Act of 1965 and the PPCA of 2010). This episodic, staccato-like feature of major changes may imply a greater importance of executive action (Blumenthal and Morone 2009), conditional on opportunity windows for change arising. Yet as Hacker and Pierson (2011; see also Hacker 2004) have argued, much of the critical "action" in fact rests in policy inaction, as social policies ranging from insurance to the minimum wage to regulation are undermined (and sometimes strengthened) by the

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[4] European Commission 2007; *Health and long-term care in the European Union* [http://ec.europa.eu/public_opinion/archives/ebs/ebs_283_en.pdf, QA4.1-QA4.6 and QA5.1-QA5.6, pp 176-187].

failure of attempts to reform them. These non-developments are, often enough, as fully under the conscious watch of politicians as are the enactments of the initial policies themselves. In health, new medical procedures and products, new diseases (and understandings of disease) and new populations may arise or change, and in the absence of action health insurance regimes may not provide access or regulation for these goods or patterns. Exogenous and endogenous changes in the cost of care, or general price inflation, may undermine the effective reach of insurance. The manner in which governments, politicians and administrators deal with, or ignore, these problems and processes is a critical research agenda for health politics scholars in the years to come.

There remain, to my thinking, several critical questions for political scientists to address in the study of health services and insurance. Among the first is the level of government question: why health insurance in the provision of health services seems so often to be the province of national states, with two important features of variation: (a) the variation provided by cases in which sub-national governments above the city level provide insurance of some kind (such as in Canada or particular state-level insurance supplement politics in the United States (Volden 2002); (b) the variation by which other (non-insurance) characteristics of health services (vaccination, quarantine, infrastructural interventions) are so often provided by local governments. Surely one answer to these questions rests in the superior resource extraction capabilities of national states via-a-vis international regimes or sub-national governments. Yet the puzzle here is larger than this.

Second, while much of the literature in health insurance and services has been focused upon the government and political decisions in comparative and historical context, there are critical cross-regime and trans-national flows and dependencies that deserve greater consideration. For instance, European systems of health insurance have provided the principal “grist for the mill” of comparative and historical literature, but their influence is in fact greater than this. European systems also have provided models for emulation and criticism; their parameters and institutions have shaped the evolution of policy in other, non-European settings. Longstanding proposals for "Medicare for all" from Democratic politicians like the late Senator Ted Kennedy, for instance, were based partially upon observations of the French national health system. Alternatively, arguments for a more individualized, privately-based system of health insurance often gesture to alternative European models (Herzlinger 2004). This is an important research agenda item for future work. At the sub-national level, there is emerging evidence that states learn from one another in their adoption of critical features of children's health insurance (Volden 2003).

What, then, is plausibly different about health politics in the provision of insurance and access? The tendency of nations to grant broad access to health services and, in puzzlingly varied ways across time and space, to aim for reduced inequality of access among citizens even where other inequalities are tolerated and legitimated.

2. Health Regulation and Infrastructure: The Role of the State and Organized Expertise

Licensure and Legitimation. Health politics may be different in another way: its unique reliance upon, and expression of, *the co-organization of expertise and state power*. This difference is one of degree more than of kind; experts play critical roles in national and international debates over environmental policy, energy policy and of course economic and security policy. Yet the co-evolving roles of state and organized expertise in health show some features that are rarely, and sometimes never, duplicated in other realms. In variable ways that nonetheless span the globe, governments and societies endow legitimated healers with particular legal authority and cultural power. In many advanced, industrialized countries, officially legitimated experts alone have the power to prescribe and deliver medicine or medical procedures to citizens. Individuals without legitimation who attempt to provide medical services or products to a country's citizens can be, and often are, prosecuted for violations of national or sub-national statutes. There are many societies in which the legitimation applies to traditional healers, but the most common form of legitimation occurs in the granting of professional status to healers and the concomitant licensing of these professional healers for the practice of medicine (Abbott 1987, Freidson 1988, Rothman 1991, Starr 1984).

The organization of medical talent is not merely a social and economic fact – not merely a process by which healers organize themselves to differentiate themselves from others, endow themselves with status, and restrict the supply of their services and thereby drive up their income or increase consumer confidence in the provision of services – but an explicitly political reality. In many Western nations, the process by which physicians, nurses and other health professionals receive licensure is governed explicitly by the state, which grants medical and health service licenses. (In many cases, state licensure arrived along with or before the emergence of well-organized professional lobbies; state policies were not then, and are not now, simply an epiphenomenon of professional organization (Abbott 1987).) In other ways, governments may also shape who gets to provide health services by regulating hospitals and other care facilities, or by restricting those who can prescribe medicines or process payments under a government health insurance plan.

In the operation of licensure, medical authorities and state authorities (often people who travel in both sectors) usually devise standards of training, examination or testing, and professional entry (Abbott 1988, Freidson 1988, Starr 1984). In advanced industrialized countries in western Europe, Australia and Japan, these processes are carried out at the national level, whereas in the United States, medical and health services licensing is a sub-national affair at the state level. In general, the politics and political economy of licensure has been little studied among political scientists, and it represents an obvious research agenda in years to come, not least because these matters have been, and will continue to be, contested at the micro-level (nurse practitioners vying with doctors for control of clinical practice and laboratory work, for example) and the macro-level (governments and insurance companies regulating who can supply government-provided or –subsidized medical care).

Not surprisingly, those who are endowed with the license and status of legitimated expert and healer have both a natural basis of organization (the labels that allow for identification and status, health incomes, and ready-made professional networks and organizations) and a robust pattern of mobilization. Organized opposition from physician groups has been one of the principal obstacles to American legislation creating national health insurance (Starr 1984, Quadagno 2005, Chapin 2010), and as national regimes worldwide begin to grapple with cost containment in health care, pitched battles between physician groups and other health service provider interests, on the one side, and government agencies and insurance providers, on the other, can be expected to grow in frequency and intensity.

The co-evolution of professions, state licensure and medical practice has been important in another way, namely that physician organization represents a partial brake upon, and a partial conduit for, the influence of medical products and services companies such as pharmaceutical and biotechnology corporations, hospital corporations and insurance companies. As studies in law and history of medicine have documented (Rothman 1991, Rodwin 2011), physicians have developed institutions and norms for regulating "conflict of interest" and for the maintenance and renewal of "bioethics." These institutions can be thought to represent a force shaping the production and delivery of health services that is differentiable both from (a) the politics and organization of national health insurance that would seek to impose larger social policy aims upon the delivery of care, and from (b) medical product and insurance companies that would seek to shape health services to their ends. Yet precisely because health professionals have gatekeeping power over heavily demanded medicines and services to which patients attach hope, health professionals both individually and collectively are the target of vast campaigns to influence their perceptions, judgments and behavior. The way that governments and professions regulate these conflicts of interest is highly variable across societies

(Rodwin 2011). Some nations prevent companies from advertising to doctors and even restrict the ability of company representatives to meet with physicians. All but two nations (New Zealand and the United States) altogether ban direct-to-consumer advertising of medical products. In other settings, physicians themselves constitute and populate the major decision-making bodies that decide health policy issues of vast significance, including what gets listed on a national formulary, what medical procedures qualify for reimbursement, what grant applications for clinical research will get funded, and others. Again the political science literature is nearly silent on these questions.[5]

Beyond the licensure of individual medical services, two other features of health service regulation and legitimation deserve greater scrutiny. First, governments and societies differ in the degree to which they regulate health service organizations such as hospitals and medical clinics. In the United States, these organizations are regulated at multiple levels of government, not least through state-level agencies and restricted entry through “certificates of need.” In Britain, hospitals rest under the penumbra of the National Health Service, while in France they are regulated more directly by regional agencies under the ministry of Health and there is a significant proprietary sector (Rodwin and Sandier 1993). Second, there are varying degrees to which putative errors made in the practice of medicine or healing are subject to lawsuit or are “tortiable”; the United States saw relatively strong physician organization in the 20th century (Starr 1982, Chapin 2010) yet also has one of the larger tort-based regimes of medical malpractice. There is not strong evidence, however, that medical malpractice is a primary driver of the extreme spiral of health costs in the U.S. (Baker 2005).

Regulation of Medical Products – Gatekeeping and Conceptual Power. The power of the state is also somewhat different in the arena of health. Not only are many medicines and medical products separated from the citizen by the gatekeeping agency of the physician or health professional, who must

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[5] Yet it is worth noting that in the absence of independent professional authority and professional ethics, there would little or no understanding of “conflict of interest” at all.

prescribe or authorize patients to consume them, but in nearly all countries worldwide most medicines must be authorized for marketing and prescription by a government agency before doctors or patients can use them. As Carpenter (2010) argues, this degree of control over product entry into new markets is rare in the global regulation of industries and markets, and it is to a great degree premised and practiced upon emulation of one or another aspect of "the American model" of pharmaceutical regulation by the U.S. Food and Drug Administration (FDA). It is common to justify such regulation by the safety risks and/or information asymmetry between the producer of these products and their consumers. Yet while a vast array of other products poses great health and safety risks to consumers, governments do not require their pre-market approval by administrative agencies before they reach the consumer. So too, many other examples of 'credence goods' (repair services and, by some accounting, financial products) exist where there is no discretionary administrative gatekeeper separating the consumer from the product.[6] In many respects, physician services and professional licensure would appear to be the closest analog to pharmaceuticals, yet it is remarkable that in many countries, the dominant professional organizations of medicine play little direct role in drug and device approval.

The regulation of pharmaceuticals has long been a central concern of political scientists (Quirk 1980; Marks 1997; Carpenter 2002, 2004, 2010; Carpenter and Ting 2007; Moffitt 2010; Maor 2011). Several features of this form of regulation – termed "approval regulation" by recent scholars (Carpenter 2004, Carpenter and Ting 2007) precisely because of the gatekeeping power of the state – are of interest. First, it has been shown that in the regulation of new drugs, agencies such as the FDA are typically not shaped, at least not linearly or in the short-term, by the ideological or partisan composition

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[6] In the standard typology of goods as defined in microeconomic theory, "ordinary goods" are those in which quality is immediately observable (goods in general equilibrium theory), inspection goods are those whose quality can be observed without purchasing the good (trying out a hammer at a hardware store), experience goods are those that need to be consumed or purchased in order for their quality to be inferred (an internet service, a job, for example), and credence goods are those whose quality cannot be known even after purchase and consumption.

of the politicians overseeing them (Carpenter 2002). Second, while pharmaceutical and medical product companies have vast power, this power falls far short of dominance (Carpenter 2010), and much of the evidence amassed for the hypothesis of capture or industry dominance in fact fits with other explanations (Carpenter 2004). Third, the form of politics that most heavily shapes drug and device regulation in the United States and worldwide is not partisan or ideological politics, and not even distributive politics or moral politics, but a politics of legitimacy or reputation (Carpenter 2010, Moffitt 2010, Maor 2011). This is not to deny the vast, and growing, power of the global pharmaceutical industry. Yet that industry has developed within the structure imposed by global drug regulators (especially the FDA), not vice versa, and many of the critical developments in global pharmaceutical regulation arrived over the explicit and coordinated opposition of companies.

[Table 1 about here.]

An important feature of global pharmaceutical regulation is its high degree of standardization. Compared to the wide variation in national health insurance systems and in public health programs, the development of medicines (and to a lesser extent, medical devices) appears to be characterized by a stable system of institutions that, while not universal, shares some highly common features (Table 1). To begin with, the approval of medicines is conducted worldwide by agencies of the state, most commonly national government agencies, but also pan-national agencies like the European Medicines Agency (EMA). Private and public organizations developing new medicines must submit a collection of documents to apply for market authorization. (Reflecting the range of legal and technical concepts available, this has the name of a new drug application (NDA) in the United States, “demande de autorisation le mise sur le marché” (Demande d’AMM) in France, and in the EU and in international circles, it is increasingly called the Common Technical Document (CTD) (permitting in theory one electronic application to numerous governments). The requirements for clinical tests attached to these dossiers have popularized and reified the three-phase clinical trial system and, in large measure, the randomized clinical trial as the dominant mode of medical science and progress. Once on the market, drugs must be manufactured according to set of guidelines called "good manufacturing practices." Brand-name drugs can be replaced by generic drugs, but only after these have demonstrated "bioequivalence" – roughly the idea that the generic drug performs the same in the body as does the brand-name drug, with tests using blood samples. In short, from inception to commercialization, drugs and other medical products pass through, and are governed by, a set of institutions and procedures that display remarkable similarity worldwide.

The source of this standardization varies. In part, as Carpenter (2010) argues, it reflects the reputational force and the various regulatory powers of the American FDA, whose rules, concepts and practices have been copied – sometimes in faith, sometimes ceremonially, and often with partial or full resistance – the world over. From the period in the 1960s when the thalidomide crisis – the global tragedy of thousands of stillborn and deformed children whose fates were determined by a sedative sold widely without pre-market testing and which, symbolically, did not make it onto the United States market due to the action of the FDA – compelled nations to re-examine their pharmaceutical institutions, through the 1980s, the FDA was the world's primary model for medical product regulation. Regional and global institutions such as the European Economic Community and the World Health Organization contributed to standardization, but often by adopting and recommending some basic precepts of the FDA model. In recent years, the EMA has become a more common source of inspiration for developing countries (such as for Brazil and its Agencia National de Vigilancia Sanitaria (ANVISA) (Massard da Fonseca 2011)). More commonly from the 1990s to the present, the standardization of medical product regulation has become a conscious, planned affair, with the rise of the International Conference on Harmonization (ICH). The ICH played a central role in developing the Common Technical Document and in revising clinical trial and manufacturing standards; it represents a pivotal arena in which global pharmaceutical companies can leverage their power with national regulators, a forum in which consumers and other interested parties do not make a significant appearance at the table.

While abundant similarities in institutional form for medical product governance gesture to the power of regulatory and global institutions, they also enable interesting cross-national comparisons (Maor 2011). When so much about health product governance is standardized, the cross-national differences become clearer upon examination and the similarity provided by standardization offers a ready-made set of "control" variables that have already been accounted for. In an interesting paper, Maor (2011) examines institutions used by various governments to warn their citizens of drug problems. Noting that different nations' regulatory agencies have reputations for different strengths (some prize their scientific and technical image, others their image in consumer protection), Maor examines how the content of these different reputations shapes the mode of announcements. Public health warnings thus merge with agency public relations and audience management.

The increasingly global world of pharmaceuticals is both cause and effect of the globalization of the pharmaceutical industry. Global companies maintain an economic and political presence in numerous countries; this fact refracts but also multiplies their power, as national officials can lobby one another and companies can fight a policy in one country by threatening to move capital and labor to another. So too, as venues of standard-setting move to the global arena, global pharmaceutical companies are uniquely positioned to shape the formation of concepts, methods and guidelines. Much more than other global players (the World Health Organization, for instance), global health companies bring serious capital and resources to the table, a level of resources and legal power matched only by national states. These patterns of growing global corporate power in health require more attention, not only from political scientists but from all social scientists.

What, then, is plausibly different about health politics in the regulation of services and treatments? The convergence of nations upon the broad parameters of an "approval regulation" model of health products governance, with strong empowerment of professionally and governmentally-legitimated scientists and healers.

3. Identity, Disease and Global Health

Health politics involves claims about identity and representation that both map onto existing lines of difference – gender, racial and other identities; political ideology; partisanship – and create and refract new lines of difference. The manner in which health politics shapes these new forms of politics has much to do with arguments over public spending and public functions. Yet they also concern the intimate relationship between health, human experience as lived tangibly and physiologically, and well being. Health, and hence health politics, often touches physical human experience in particularly direct and tangible ways. Health is, again, a constitutive part of human welfare and human identity, involving our motor abilities and capacity to move (hence affecting our employment, and our citizenship), shaping our mood (hence our personal expression and features of our identity), shaping our sexual function and procreation, and affecting those around us (our kinship networks and communities). It is, to put matters differently, one thing to discuss the lived bodily experience or the prospect of illness and death in a debate about financial regulation, employment prospects, even counter-terrorism policy. Yet these intimate and tangible matters occupy “center stage” in health politics, infusing it with different meaning and emotive content. So too, discussions over what might, in other settings, be considered private and physical, often enter the contestation of health politics – a cancer of the breast or testes that might deserve special research or access to services, a disease disproportionately common in a marginalized population and how its sufferers should be identified, an infective illness and the role of government coercion in reducing its spread. Health and illness shape who we are politically.

If ever a "test case" arose in which these dynamics of identity were revealed, it came in the explosive carnage wrought by the global epidemic of acquired immune deficiency syndrome (AIDS). The global AIDS crisis, which first came into scientific and public awareness in the 1980s, transformed the global public health agenda and much of modern health and sexual culture. United Nations officials estimated in 2010 that approximately 33 million human beings were living with human immunodeficiency virus (HIV), and over the past three decades AIDS-related illnesses have claimed over 25 million lives. AIDS has spawned vast movements of human compassion and broad movements of discrimination. In health policy, nations and cultures responded in starkly different ways to the crisis; some governments were more aggressive in responding to the problem, others much less so. In a perceptive study that marshals qualitative and quantitative methods, Lieberman (2009) illuminates the role of ethnic fractionalization in shaping policy responses to AIDS. "When countries have strong, internal boundaries dividing societies into substantial and recognizable *ethnic* groups," Lieberman argues, "the epidemic is also likely to be understood in ethnic terms." Pre-existing institutions (formal boundaries and formal and informal categories) altered the very perception and social experience of disease. In those nations where ethno-linguistic fractionalization was high, "discourses about the risk of being infected and affected by AIDS [were] infused with ideas about ethnic difference." Lieberman's study suggests that, in its intersection with ethnic division, health politics both resembles and departs from other domains of contestation and cooperation. Lieberman's case analyses (Brazil, India, and South Africa), international comparisons and quantitative studies do *not* support the explanatory power of distributive politics or ethnic rent-seeking. The multidimensional politics of AIDS in developing countries are instead deeply shaped by a politics of blame, legitimacy and reputation. And in ways that speak to the differential force of health politics, Lieberman compares AIDS to the causal power of war in state-building, writing that "AIDS has provided a new exigency for state power, as well as for the powers of global governance ."[7]

AIDS channeled older political energies and engendered new ones on both global and national canvases. In the United States, the initial appearance of AIDS among gay male populations both created new stereotypes and reinforced deeply embedded animosities and misunderstandings toward gay, lesbian, bisexual and transgender populations. In an insightful work of political science and ethnography, Cohen (1999) explores the divisive nature of AIDS within black community politics. In ways that echo and presage the emerging divisions of class politics among African-Americans, the arrival of AIDS exposed and engendered divisions both silent and stark among black Americans. A homophobia that had often lay dormant and out of public view became explicit. AIDS thus changed not only black health politics, but black community politics more generally. Racial and community identity premised upon linked fate and common experiences of discrimination was split open by the creation of a newly marginalized community within an already marginalized population. In Cohen's study, health politics marked and created a different politics because it shattered the cohesiveness of an earlier identity, exposed latent fault lines in ascriptive and historical communities and starkly created and reinforced new divisions.

The global, national, and local effects of AIDS are still being felt in ways that deserve continued study. There remain rich questions for political scientists to pursue. Scholars could follow Cohen (1999) and ask whether particular ethnic groups with previously cohesive identities (at least along some dimensions) have struggled with new divisions. Scholars could follow Lieberman (2009) and examine quantitative indicators of government response to AIDS, especially sub-nationally where there remains considerable work to be done. Or they could examine some of the cases that Lieberman chose not to

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[7] It is important, however, to distinguish the politics of politicians' reputations in an environment of formal and informal ethnic tension from the kinds of organizational reputations mentioned above.

study more closely – China, Sri Lanka, Argentina, western Africa. And political scientists can and should examine those dimensions of experience where the politics of AIDS may not be unique, where the politics of cancer, tuberculosis, Tay-Sachs, sickle-cell anemia, and other illnesses shape new and old political divisions within and across marginalized communities.

Contestation and Conceptual Power: How Health Politics Shapes the Medical and Health Sciences. Whether exercised through professional orders and hierarchies or through the standard-setting and veto force of regulators, the conceptual power of experts and the state remains contested. Important features of modern science and health – even the use of certain statistical measures and estimators – have been shaped by political, administrative and interest group factors. Beyond the studies of pharmaceutical regulation mentioned above, two insightful studies by Epstein (1998, 2007) demonstrate the shaping role of politics in science and medical knowledge. In an examination of the AIDS crisis, Epstein demonstrates how AIDS activists were able to challenge, and then reshape, paradigms of law and medical science such as the placebo-controlled trial, the phased-drug system, and the control of experimental medicines, not to mention public research funding. AIDS groups did so not merely by directly challenging government agencies such as the FDA and the National Institutes of Health (NIH), but also by taking matters of clinical treatment and experiment into their own hands. Gay men's and AIDS groups opened their own pharmacies and treatment centers. They organized their own experiments and, in effect, created their own laboratories. They recruited scientists more sympathetic to their concerns about an alternative ethics and methodology of experiment. Not the least of the fruits of their efforts were significant changes to the FDA's drug approval paradigm (Epstein 1997; Carpenter 2010, Chapter 6), with the introduction of fast-track approval procedures and "treatment investigational new drugs" (treatment INDs), in which drugs could be released for marketing on a compassionate basis before all three phases of clinical testing had been completed.

In a more recent study of how minority populations get excluded from and included in medical research studies, Epstein (2007) shows how a form of identity politics shaped concepts of causal and statistical heterogeneity – not merely the idea that human subjects are different, but that some treatments might have different effects in and among these different groups. Women's groups and racial minority organizations successfully pushed for the creation of embedded representation bureaus inside federal health agencies (e.g., the FDA's Office of Women's Health, and the Office of Research on Minority Health (ORMH) at the NIH). They also pushed for the creation of statistical subsamples (sometimes oversamples) of their population. In so doing they gave powerful political force as well as social rationales to the idea of "subgroup analysis," where the hypothesis tested in a statistical study would be tested within and between various subsamples that are differentiated by gender, race or another marker of identity. So powerful were these forces that now widely accepted methods such as "subgroup analysis" and examination of "heterogeneous causal effects" of medical treatments can be said to owe their origins, in part, to what began as a political critique of exclusionary practices. The insistence of contemporary statisticians and social scientists in talking about "average treatment effects" is a silent bow to this stunning new reality; if there is a population of treatment effects and the causal effect of a medicine or even policy will differ by the race, gender, ethnicity, identity or social positioning of the subject, then much of the simpler statistical paradigm of the twentieth century must be conditioned. Causal effects are, under this reasoning, "contingent." Epstein's creative and careful analysis deserves application to other settings, not least global health.

Voice, Money and Illness: Political Organization and Publicity by Disease. The experience of AIDS has become a paradigm for another set of understandings, namely that differentiation among illnesses can create a form of distributive politics. A critical set of limited resources – research money, funding for insurance reimbursement, public attention and philanthropy, legislative initiative, even compassion itself – can be divided among ascriptive "interest groups," which in recognition of this distribution organize and render public and private claims upon these resources. The process is undoubtedly more complicated than this, for the attribution of group in-status for someone with an illness often proceeds much more opaquely, contingently and less public than, say, the process of ascribing gender, ethnic or racial identity. Yet the comparison is meaningful, not least because the past thirty years have witnessed an immense growth of disease-specific associations and lobbies in American national politics (Greenberg 1998; Armstrong, Carpenter and Hojnacki 2007).

A classic article by Colby and Cook (1991) asked why AIDS coverage varied so heavily even as the underlying epidemiological and pathological fundamentals of the disease did not. Colby and Cook systematically examined the changing nature and level of nightly news coverage of AIDS. In ways that contrast partially with Epstein's (1997) narrative, Colby and Cook find that gay news media had less access to critical government sources of information, and that, conditioned on such sources of information, much of the news reporting on AIDS in the 1980s took, for better or worse, a tone of reassurance to the mass American public.

Political scientists and sociologists, among others in communications studies, have recently begun to expand upon these findings. Armstrong, Carpenter and Hojnacki (2007) examine a panel of news coverage for the fifteen most common causes of mortality from 1980 to 1998. They find that AIDS is different in so many respects that it must, under many conditions, be examined separately from the other illnesses. They also find that eight of these diseases received so little public news coverage that there was too little data for statistical analysis. Among the remaining seven, Armstrong, Carpenter and Hojnacki find a positive but small association between changes in mortality and overall coverage, and a rather striking association whereby increases in the fraction of incidence among African-Americans predict corresponding declines in the television and print news coverage of that illness. These findings are merely suggestive, the authors point out, and await historical and ethnographic research as well as more general quantitative analysis of samples with a wider disease sample.

Financial resources themselves compose an obvious target of inquiry for studies of the distributive politics of disease. For biomedical inquiry in the United States, the principal focus of attention is the National Institutes of Health; perhaps not surprisingly, given the population dynamics and incredible cultural force of cancer in American society, the National Cancer Institute (NCI) remains by some margin the largest and most powerful of NIH institutes. A range of studies in political science and political economy have recently begun to examine the disease-based distribution of biomedical research funding (e.g., Hegde and Mowery 2008). While these studies are valuable, it is important to approach these disease-based measurements of funding with caution, as research funds are often not neatly targeted to specific etiologies or illnesses but are often couched in broader terms of pathological mechanisms of illness. In nations with an important public funding role in health insurance and where government or para-public entities play an important role in determining which procedures and treatments qualify for national health insurance coverage, political scientists might examine lobbying by disease-specific associations for treatment coverage. In the United Kingdom, the National Institute for Clinical Excellence (NICE) conducts cost-effectiveness and comparative effectiveness analyses and renders coverage decisions. Directly and indirectly, its processes and decisions are the subject of considerable political pressure, and as of this writing the Cameron government in Britain has decided to curtail NICE's power. In the United States, the Centers for Medicare and Medicaid Services (CMS) of the Department of Health and Human Services has played such a role, as it renders coverage decisions for the Medicare program. When in the summer of 2011 the FDA considered whether to remove the breast cancer treatment indication from the drug Avastin (bevacizumab), breast cancer representatives were divided on the issue, and CMS decided to retain Medicare coverage for Avastin for breast cancer, irrespective of the ultimate decision of the FDA.

What, finally, is plausibly different about health politics in its patterns of identity and difference? The way in which illness creates identities and political organizations (latent and explicit) that would not otherwise arrange themselves along the same lines of cleavage, and the way in which the resulting identity politics shape scientific and technical concepts and methods.

Conclusion

> "Housing policy is health policy. Educational policy is health policy. Antiviolence policy is health policy. Neighborhood improvement policies are health policies. Everything that we can do to improve the quality of life of individuals in our society has an impact on their health and is a health policy." – David Williams, in the 2008 documentary *Unnatural Causes*

I have claimed here that health politics is somewhat different from other realms on the dimensions of equality and justice claims, the role of legitimated professional sponsors, organizations and regulators in its governance and provision, and in the complex of identity claims that emerge from the politics of disease. I have not claimed that health politics is unique, but it would seem sufficiently distinct as to deserve a separate subfield in political science.

Appropriately, the field of health politics is just now getting organized in political science, with a Health Politics section recently established in the American Political Science Association. Yet political science's arrival to the realm of health has been slow. By comparison, health-specific fields have long been active in every other social science discipline, viz. medical anthropology, the history of medicine, health economics, medical sociology, etc. Political scientists have both a challenge and an opportunity, then, in bringing their vantages, methods and professional identity to the study of health. As David Williams of the Harvard School of Public Health reminds viewers in his 2008 film *Unnatural Causes*, the challenge of studying health can be daunting. It touches on so many dimensions of human experience. Appropriately, the review here has been limited in its objectives and in its reach.

As the field of health politics progresses, there are a number of particular questions to which scholars should orient their inquiry. To inject my own judgment more directly, I would call for a strong degree of methodological pluralism – one that existing studies of health politics have already shown, but which can be improved upon, and one that is necessary for a richer understanding of health politics. Consider the following subjects, puzzles and questions:

- Issues of federalism: what is the level of government at which health services or regulations are rendered, promulgated and enforced?
- Transnational and cross-governmental diffusion and dependence in health politics; how do governments and publics emulate and resist the models and actions of others?
- Licensure and legitimation of medical services, organizations and professionals by government and non-government entities and the comparative political organization of hospitals, physicians, nurses and other health service providers; the application of licensure and legitimation to traditional healing systems such as Ayurveda in India and Sri Lanka;
- The gatekeeping and conceptual powers of regulatory agencies governing medical products (drugs, devices and traditional healing products), especially comparative studies and studies of arrangements in developing countries;
- The politics of tobacco control (Brandt 2007, Derthick 2002), both in the United States (which has enacted sweeping legislation in the family smoking Prevention and Tobacco control Act of 2009), and globally, as international health agencies and developing countries attempt to restrain the growth of cigarette consumption among their populations;
- The politics of obesity, both as a critical policy issue and as a dimension of difference that is intimately and troublingly bound up with race, gender and class; the public health strategies and institutions of obesity in the developing world seem of particular relevance for political scientists;

- public health agendas and agencies at the local and national levels, and the process by which foundations, national states, disease lobbies and global health companies shape them;
- the growth of global corporations and their political power in health services provision and health products, and in national politics generally.

I conclude on a historical note, namely that in the early 20th century as American political science was launching its professional networks and forging a new identity, we would not be having this conversation (or, at least, not having anything like the same conversation). The scholarly analysis of health and health politics focuses, appropriately, upon recent policy developments and population health changes. Yet we should not ignore or surrender the longue duree perspective by which health expenditure now dwarf national security expenditures and many other categories of effort, expenditure and division. The significant growth of human civilization and the elongation of human life has laid the foundation for some of its most gripping and divisive controversies. Divisive battles over health insurance have arrived in part because human societies have reached a certain level of wealth and health. Historically, poorer societies of short-lived human agents were more likely to battle over other questions. These patterns will endure, and they will render health politics more important – and perhaps more differentiable from other realms with which political scientists are both comfortable and familiar – in the decades to come.

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Table 2: Cross-National Dependencies in Global Pharmaceutical Regulation in the Twentieth Century [cells contain year of first adoption by row state of column institution]

	Unified state regulatory agency	Pre-market review	Efficacy standard	Standardized new drug application	Regulated R&D process (phased studies)	Bioequiv. & bioavail. regulation
Netherlands/ BENELUX	1958	1958	1958	1958	1975	1983
Norway	1928	1928			1975	1983
Sweden	1934	1934	1934	1971/1976	1975	1983
United States	1906/ 1927	1938	1947-1962 [informal] 1962 [formal]	1947-1956	1962	1970
United Kingdom	1963/1971	1963	1963	1971	1963	1983
France		1945	1978	1967	1995	1983
Germany/ W. Germany	1961	1961	1976	1961	1978	1983
Japan	1962	1948		1962		
Canada		1963				Late 1970s
Australia	1963	1963	1963	1989/1990	1989/1990	1990
European Union	1995	1995	1965	1965	1975	1983
China	1979	1985	1985	1985	1999	1999
South Korea	1953					

Note: Adapted from Carpenter (2010), Chapter 11. Shaded cell denotes those institutions adopted first in the United States that were substantially copied by other nations or regions. BENELUX stands for "Belgium, Netherlands and Luxembourg," who unified their pharmaceutical regulations in 1973.