The politics of health promotion: insights from political theory

LOUISE SIGNAL
Public Health Group, Ministry of Health, Wellington, New Zealand

SUMMARY
Health promotion is inherently political. Not only is it largely funded by government, but the very nature of the enterprise requires shifts in power. Political theory has much to contribute to an understanding of the politics of health promotion. In this paper three key political theories are explained and their insights for health promotion explored. They are then applied to the development of a National Drug Policy in New Zealand. The theories—pluralist interest group theory, the new institutionalism and neo-Marxist theory—are each at a different level of analysis. The significance of interests, institutional factors and class as political influences on health promotion are discussed. It is concluded that to ensure good practice health promotion practitioners need to be aware of these influences on their work. They need to strategise to ensure support from key interests, build capacity for health promotion into their institutions and recognise the macro-political context within which they work in order to influence it.

Key words: drug policy; health promotion; new public health; political theory

INTRODUCTION
Health promotion is an inherently political enterprise. Not only is it largely funded by government but the very nature of its activity suggests shifts in power. Its recognition that peace, shelter, food, income, a stable ecosystem, sustainable resources, social justice and equity are basic prerequisites for health implies major redistribution in power and wealth. Yet the politics of health promotion are rarely discussed.

Health promotion has developed over the past two decades and has been adopted by governments internationally. It is based on the World Health Organization (WHO)’s broad definition of health and is defined as ‘the process of enabling people to increase control over, and to improve, their health’ (WHO et al., 1987). Its strategies have been well articulated in the much talked about Ottawa Charter for Health Promotion (WHO et al., 1987). Health promotion is a key WHO strategy to achieve its goal of ‘Health for All by the year 2000’ (HFA 2000). Yet internationally, with less than 2 years to go, this goal is far from being met. Even in New Zealand where, by world standards, we have a comparatively high standard of health,

[T]he suicide rate of young New Zealand adults is among the highest in the world. Rates of skin cancer (melanoma) and cancer of the large bowel among non-Maori are also among the highest in the world. The lung cancer rate among Maori is twice that of non-Maori, and the rate for Maori females is among the highest in the world. (Public Health Commission, 1993, p. 10)

Health promotion has the potential to make significant improvement in these, and many other areas of health. Health promotion has been heralded by many as an innovative solution to major world problems. Has it lived up to its promise? If not, why not?
In this paper I will attempt to answer these questions by examining the politics of health promotion. I will do so using three political theories, each at a different level of analysis—pluralist interest group theory at the micro level, the new institutionalism at the meso level, and neo-Marxist theory at the macro level. I will discuss the significance of interests, institutions and class as political influences on health promotion and will draw conclusions about the limits of reform in modern Western democracies. I hope these insights will help inform, and potentially improve, our health promotion practice. In order to demonstrate the value of a systematic political analysis to health promotion practice I will apply the theory to the development of a National Drug Policy in New Zealand. It should be noted that there are other political theories which could be used to inform health promotion practice, such as the advocacy coalitions approach (Sabatier and Jenkins-Smith, 1993). In highlighting three such approaches I hope to demonstrate the value of political analysis, but not limit it.

PLURALIST INTEREST GROUP THEORY

Pluralist interest group theory, or pluralism, holds that public policy is developed according to the interests of a range of groups who compete with each other in order to influence the policy process (Latham, 1952; Dahl, 1961). The approach is concerned with identifying the interest groups in a policy arena, determining to what extent these interest groups are organised, how well resourced they are and what strategies they are adopting with regard to each other. It is a micro level theory; that is, it explains the influence of individuals and groups on the political process. It is based on a consensus view of society and argues that, as a result of the lobbying of interest groups on government, the state operates in a democratic way meeting the needs of all its citizens.

Pluralism has been criticised by many theorists for its whitewash of power imbalances in society and for its inability to explain structural and societal factors. Despite this, pluralism has had a huge influence on the theory and practice of government in Western democratic countries, particularly since World War II. As Ham and Hill (1984, p. 27) note, the importance of pluralist theory is demonstrated by the fact that, implicitly if not explicitly, its assumptions and arguments now pervade much Anglo-American writing and research on politics, government and the state.

Interest groups likely to be key in the development of health promotion, whether supporting or restraining it, are, first of all, public health professionals such as health promoters, health educators, public health nurses and public health doctors. Whether collectively or individually, we all influence health promotion policy and practice through our work. Umbrella groups such as the New Zealand Public Health Association also have an important role in the development of health promotion.

The government represents another key set of interests. I say 'set' because there are both political and bureaucratic influences and even these are not monolithic. Government agencies may, for example, have differing, and at times conflicting, agendas. A common example internationally is when the Ministry of Health has been attempting to reduce tobacco consumption at the same time as the Ministry of Agriculture has been subsidising tobacco farmers.

Business interests—particularly those involved in traditional areas of concern for health promotion such as tobacco, alcohol and food—have always had a major influence because of concern about public health interference in their trading.

Consumer groups are also important influencers, although they often focus their attention on single issues such as AIDS and mental health.

Health promotion providers, whether government agencies or private institutions, can also have a significant influence.

In analysing the power of interest groups in health promotion it is important to examine how well organised they are, what resources—such as money, political skill and experience—they command and what strategies they are using to influence the political process. Key strategies are: direct and continuous contact with politicians and bureaucrats, the presentation of submissions, representation on advisory groups, and use of the media to influence public opinion.

Internationally, support for health promotion has come from a wide range of interests which can be attributed, at least in part, to the ambiguity of the concept. As a number of writers have discussed, health promotion can mean very different things to different people (Edwards, 1989;
Baum, 1990; Grace, 1991). Baum (1990, p. 149) argues, in reference to the Ottawa Charter, that ‘it only requires a slight re-jigging of the rhetoric for it to become reactionary rather than progressive’.

The ambiguity of health promotion gives it considerable power as a political symbol. As Stone (1988, p. 126) argues, the ambiguity of symbols is essential to politics because it helps transform individual strivings into collective decisions. Symbols allow coalitions where pure material interests would divide people. They enable leaders to assemble broad bases of support for particular policies. They facilitate negotiation. They permit policy makers to retreat to smaller, less visible arenas to get things done. They quell resistance to policies by reassuring at the same time as the actual policies deprive. . . . A program or policy or speech, unlike a physical object, can be two things at once.

Stone (1988, p. 124) warns that, although ambiguity is very beneficial in the early stages of a social movement, this ambiguity ‘usually masks internal conflicts that will become evident as the movement seeks concrete policies’.

As practitioners we need to be aware of the interest groups both supporting and restraining our work. We need to strategise to address the restraining influences and build support where we can. In this context we also need to be aware of the ambiguity of health promotion. We need to recognise that as we try to put health promotion into practice differences in values and interpretations may become apparent. We need to be clear about what it is we are doing in order to avoid being reactionary when we mean to be progressive. By taking time to be clear about the interest groups influencing our work we are able to work strategically and ensure better practice.

The new institutionalism holds that policy-making is determined by the institutions in which it occurs (March and Olsen, 1984; Coleman and Skogstad, 1990). Political institutions are conceived as structuring political reality and as defining the terms and nature of political discourse (March and Olsen, 1986). The approach examines the impact of policy structures on policy process and outcome. It focuses on such aspects of institutions as the organisational structure, the formal rules of operation, the processes used and the ideas built into them.

As a meso level theory, the new institutionalism focuses on institutions such as advisory boards to government, government departments and the institution of Parliament. Despite criticism of the looseness of some of the new institutionalism’s concepts, it has much to offer to analysis of the institutional influences on health promotion, particularly given that so much of health promotion is conducted by government agencies or purchased by them.

Organisational structure is a key institutional influence. The legislated or mandated functions of institutions are powerful determinants of their work. If an institution has a clear health promotion mandate this provides considerable focus for the institution’s work. If an institution’s leaders and staff understand health promotion, and utilise its strategies effectively, this increases the likelihood of successful health promotion outcomes. Also, the power of an institution in relation to other institutions is important in determining its effectiveness.

The rules, or unwritten constitution, of an institution are also significant in determining policy outcomes. They set limits to the process of interaction used by people involved in a particular institution. In one case study of a government institution in the health promotion field (Signal, 1994), the rules identified included consensus decision-making, the depoliticisation of advice, non-partisanship and confidentiality.

The process employed by institutions is another important influence. Issues such as whether the institution has an open or closed process, whether it consults with the public, whether it is flexible and can meet the changing needs of the community and whether it co-operates with other institutions are important considerations. They bear on who is involved in the decision-making and who feels comfortable being involved.

Finally, ideas can become institutionalised within organisations, where they define the conventional wisdom in the area, set out the questions for which evidence is necessary, suggest the alternative policies that are plausibly effective and (most important), keep alternative formulations of the problem off the public agenda. (Moore, 1988, p. 72)

Ideas can be institutionalised in a number of ways: in the institution’s mandate and terms of reference; through the presence of key proponents of these ideas within the institution; through the documents considered the intellectual foundation of the institution; in the key
documents produced by the institution; and through the choice of experts asked to advise the institution.

As practitioners we need to be aware of these institutional influences on our work and strategise to build institutional capacity for health promotion. Milio (1987) has argued for new institutions for health promotion, but even within our existing institutions there are steps we can take to strengthen their capacity to develop health promotion. We need to examine their organisational structures, their rules and processes, and the ideas we build into them. The new institutionalism reminds us that ‘the organization of political life makes a difference’ (March and Olsen, 1984, p. 747).

**NEO-MARXIST THEORY**

Neo-Marxist theory is a macro level theory which allows us to situate health promotion within its broad political and economic context. It builds on the work of Karl Marx. The classical Marxist view of capitalist society characterised it as divided along class lines between those members of society who own the means of production, the bourgeoisie, and the proletariat who are forced to sell their labour in order to survive. The dominant position of the bourgeoisie enables them to exploit the proletariat, which results in continual class struggle. The contradictions of class are seen as imprinted in the operation of all societal institutions (Alford and Friedland, 1985).

The role of the state in capitalist society has been much debated by neo-Marxists, but there is a growing consensus that the state is relatively autonomous from capital. This autonomy is important in enabling the state to fulfil its two major, and often mutually contradictory, functions of creating the conditions for profitable capital accumulation on the one hand and maintaining or creating the conditions for social legitimation on the other (O'Connor, 1973). That is, the state strives to ensure an effective capitalist economy at the same time as meeting the needs of the people and thus ensuring re-election. This contradiction ‘leads to the central issue for the state: the constant possibility of economic and political crises’ (Alford and Friedland, 1985, p. 9).

There are two traditions in neo-Marxist theoretical analysis: the functional class perspective and the political class perspective. The functional perspective is concerned with ‘specifying the form and functions of the capitalist state and thereby showing the limits of political reformism’ (Jessop, 1982, p. 79). It examines how the state is structured to reproduce capitalist accumulation and capitalist rule. It involves the identification of the state’s capital accumulation strategy and the institutional means through which this strategy is promoted. ‘An accumulation strategy defines a specific economic growth model and subsumes within it the general mix of policies deemed necessary for the realization of the strategy’ (Wolfe, 1989, p. 110). This perspective requires us to examine the economic and social policy direction of government and situate health promotion within this framework.

The political class perspective examines ‘the ability of organisations to mobilise the energies of large numbers of individuals in similar situations into collective action’ (Wolfe, 1989, p. 98). The three key political class groupings are: organised capital, organised labour and political parties. The political class perspective is concerned with examining the strength and influence of organised labour and capital, the political influence they can wield through political parties, and the response of the state to this class struggle. This perspective requires us to examine the support of the business community, the trade union movement and political parties for the economic and social policy directions of government; particularly their support of health promotion.

The functional class perspective suggests that the need to maintain the effectiveness of the economy puts limits on any government’s capacity for meeting the needs of the people. The extent of the effectiveness of health promotion is ultimately limited in capitalist society by the very logic of that society.

However, health promotion has the potential to assist governments to manage their contradictory roles. With its proven ability to reduce illness, death and disability, health promotion has the potential to deliver health in an effective and cost-efficient manner—delivering health within the constraints of the economy.

The political perspective suggests that, within the limits of the capitalist state, business, labour and political parties can struggle for particular policy directions. Given the potential of health promotion, we, as health promotion practitioners, need to argue its merits and gain support for it from these groups.
Recently, a National Drug Policy has been developed for New Zealand. The goal of part one of this intersectoral policy is ‘to minimise harm caused by tobacco and alcohol use to both individuals and the community’ (Ministry of Health, 1996). Part two, on other drugs, is due for publication shortly. Implementation of this policy is likely to be more effective if the political influences on this work are identified.

**Pluralist interest group theory**

The policy will be more effective if the interests in the area are systematically defined, their potential for influence analysed and appropriate strategies determined. For example, in the alcohol area, the Alcohol Advisory Council (ALAC) is a key player. ALAC is funded by government to promote moderation in the use of alcohol and develop and promote strategies which reduce alcohol-related problems.

The active participation of ALAC will be vital to the success of the government-led National Drug Policy. Drug user groups are also a key interest. Government-funded intravenous drug user groups have played a significant role in health education about the use of clean needles and needle exchange in New Zealand in recent years. Extending this relationship to other issues has considerable potential.

School boards of trustees are also important allies because of their responsibility for the performance of all aspects of schools. Schools provide an important setting for alcohol and drug health promotion programmes for young people, one of the key groups the National Drug Policy is aimed at.

The success of the policy will depend in large part on identifying allies and working cooperatively with them, avoiding duplication of effort and ensuring there are no gaps in programme delivery.

Likewise, we need to identify those whose interests diverge from or conflict with the policy. The tobacco industry is a key legitimate interest group whose interest in selling tobacco products conflicts with the goal of minimising harm from drug use. Illegitimate players with interests which conflict with the policy are cannabis growers and suppliers. There appears to be a significant cannabis economy in New Zealand based on the growing and supply of the drug. Cannabis provides a lucrative cash crop and is particularly important to local economies, such as the East Coast of the North Island and Northland, where unemployment is high. This analysis suggests, for example, that if we are to reduce drug use in some communities in New Zealand, ensuring that alternative sources of employment are available may be an important part of the strategy.

**The new institutionalism**

The National Drug Policy involves the establishment of two new institutions: a Ministerial Committee and a Monitoring Group. The Ministerial Committee is to be chaired by the Minister of Health and includes the Ministers of Corrections, Justice, Maori Affairs, Police and Transport and the Associate Minister of Education. It will meet twice yearly to review progress and decide which new policy initiatives should be recommended to government. The Monitoring Group is to be chaired by a Ministry of Health official and includes officials from the key government departments and ALAC. It will ensure that policies and programmes throughout government are consistent and mutually supportive.

In both cases, the mandated function of each institutional arrangement is to minimise harm caused by drugs to both individuals and the community. The commitment to health promotion of those involved will be significant to the success of the policy. The involvement of a range of ministers and ministry officials in the two groups provides the opportunity for intersectoral collaboration at the highest level. Because drug use and its impact is the business of so many government agencies, this collaboration is essential to a significant reduction in drug-related harm in New Zealand.

The rules and processes employed by both institutions will also be important. A key principle of the policy is ensuring that the needs of Maori are addressed by enabling development of specific strategies acceptable to Maori. This principle is recognised as vital to the success of any health promotion policy or programme in New Zealand. In this instance, it binds these two institutions to operating in a culturally effective manner. Ensuring public participation in the development and implementation of policy and programmes is an important process issue for successful health promotion. The process of developing this policy has involved two rounds of public consultation: the
first on an issues paper and the second on a draft of the policy. This has increased support for the policy and ensured that the policy benefits from practical experience and evidence of effectiveness. Consultation during the implementation of the policy will ensure this continues.

Health promotion ideas are deliberately built into the National Drug Policy. One of the priorities of the policy is ‘to enable New Zealanders to increase control over and improve their health by limiting the harms and hazards of tobacco and alcohol use’ (Ministry of Health, 1996). Health promotion programmes such as ‘Healthy Schools’ and ‘Healthy Workplaces’ are strategies to be utilised in the policy. It is important that the ideas of health promotion continue to guide the implementation of the policy if it is to be successful in reducing drug-related harm in New Zealand.

Neo-Marxist theory

The National Drug Policy was developed by a conservative government at a time of economic rationalism characterised by economic restraint and an increased focus on individual responsibility. Clearly, drug use costs the New Zealand government considerable money every year. Recently, the financial and social costs of alcohol misuse alone in New Zealand were estimated at approximately $1.5 billion per year (extrapolated by the Ministry of Health from Collins and Lapsley, 1991). To date, the policy has failed to attract significant new money; not surprising in this period of economic restraint. However, it advocates a comprehensive range of strategies to reduce drug-related harm, including healthy public policy initiatives, such as investigating the feasibility of introducing photographic proof of age for use in licensed premises, and community development projects focused on reducing drug-related harm.

Since the initial development of the policy a new government has been formed—a coalition between the conservative party responsible for developing the policy (National) and a more centrist party (New Zealand First). There is a challenge for those working in the drug and alcohol field in New Zealand to encourage this new government to strongly support this policy.

The implementation of the National Drug Policy has the potential measurably to reduce drug-related harm in New Zealand over the next few years by enabling comprehensive, intersectoral solutions to the complex problems in this area. However, given the continuing pressures for economic restraint in New Zealand and the significance of the drug industry to the New Zealand economy, this potential may not be fully realised. The establishment of two new institutions will facilitate the implementation of this policy and the co-operation and support of key interest groups will help sustain it.

CONCLUSION

In this paper I have analysed the politics of health promotion by examining insights from three political theories—pluralist interest group theory, the new institutionalism and neo-Marxist theory—and applied them to the development of a National Drug Policy in New Zealand. I have argued the importance of interests, institutional factors and class as political influences on health promotion.

In discussing these influences I have addressed each one independently. However, it is also helpful to consider them in relation to each other. Alford has argued that each successive level of political structure ‘sets limits upon the other levels, but does not completely determine structures within them’ (Alford, 1975, p. 153). That is, the very class nature of society sets broad limits on the types of institutions which can arise and the sorts of interest groups which have power, but does not fully determine either. Likewise, the nature of institutions sets broad limits on the capacity of various interest groups to influence policy, but does not determine how they will act, as this is done according to the principles of interest groups. This implies that, despite the best intentions of interest groups and individuals, political institutions and the very logic of capitalist society put limits on their capacity for reform. Likewise, the capacity of progressive institutions is limited by the very nature of the capitalist state.

As health promotion practitioners it is essential that we reflect on the political influences on our work in order to ensure good practice. It is important for us to ensure support from key interest groups, to build capacity for health promotion into our institutions and to recognise the broader political and economic context within which we operate in order to advocate for health promotion. We must also recognise that there are limits to reform in capitalist economies, and that given this our progress may continue to be slow.
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Address for correspondence:
Louise Signal
Senior Advisor (Health Promotion)
Ministry of Health
PO Box 5013
Wellington
New Zealand

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