What are governments for?

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Government actions to protect the public's health are not always consistent

What, if anything, will move a government to intervene to improve the health of its population? Government action seems to depend not on how many people will die if it fails to act but rather who they are and how they will die.When almost 3000 people died after aircraft were flown deliberately into buildings in Washington and New York in 2001, the United States government moved rapidly, with no regard for cost. In an unprecedented move, it immediately grounded all aircraft flying over the US, allowing them to fly again only subject to sweeping restrictions on what could be taken on board. Had the government failed to act rapidly, it would undoubtedly have faced widespread condemnation, not least from the representatives of corporate America, which had, in the attack on New York, been the target of mass murder.

Yet, of all the Americans who died in 2001 as a result of violence, only a fraction were killed in the attacks on 11 September. More than 10 times as many fell victim to firearms, either at their own hands or the hands of others.[1] Successive US governments have steadfastly refused to enact effective gun control, seemingly unmoved even by tragedies such as the mass shootings at Columbine High School in Colorado in 1999 and Virginia Tech (Virginia Polytechnic Institute and State University) in Blacksburg, Virginia, in 2007. In 2004, President George W Bush allowed a law banning sales of semiautomatic assault weapons to lapse at a time when his government was enacting unprecedented security measures in what is termed the "war on terror".

Utilitarian principles

If it is not the body count that drives politicians to act, what is it? Perhaps, in the rational world that we often aspire to inhabit, it is pragmatism. Knowing what works is purported to be a key principle by some politicians who ask us to vote for them on the basis of their technical ability and experience. Unfortunately, this does not seem to be the answer either. In 1967, the US Federal Government held back funding for highways from states that did not mandate the use of motorcycle helmets. Deaths among riders fell markedly. In 1976, under pressure from bikers' groups, the US Congress reversed this policy, leading to a marked increase in deaths in those states repealing the laws.[2]

When should governments act?

When, if ever, is a government justified in taking action to improve the health of its population? It is easy to see why this seemingly simple question leaves so many people confused. Maybe we can look to philosophers for guidance. The most frequently quoted, in this respect, is the 19th century British philosopher, John Stuart Mill. In his classic text, *On liberty*, he argues that "the only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is to prevent harm to others".[3] Yet, he also recognised that individuals are not always able to make free choices, a view shared by Karl Marx, who argued that "men make their own history, but not of their own free will; not under circumstances they themselves have chosen but under the given and inherited circumstances with which they are directly confronted".[4] The question of how these arguments apply in any given circumstances is at the heart of the dilemmas that confront public health advocates.

In applying philosophy to public health, the first question is whether an action threatening an individual's health causes harm to others. In some cases, such as drunk driving, the answer is obvious. In others, such as the harm caused by passive smoking, epidemiological research has been required to provide the answer.[5]

These examples deal only with situations in which there is direct physical risk to others. It has also been argued that, by consuming collectively funded health services, an individual engaging in self-destructive behaviour is harming others by using resources that would otherwise be available to those falling ill through no fault of their own.[6]

This argument can be taken further. There is now compelling evidence that ill health in a population weakens economic growth, because, with illness, people reduce their labour supply and productivity.[7] Is this a justification for governments to act? Certainly, governments intervene in many other ways to promote growth, through fiscal policy and direct investment in research, skills and physical infrastructure. So far, few have accepted explicitly the importance of investing in the health of their population as a strategy to promote growth, even though, in some analyses, this provides a greater return than investment in education.[7]

The second question is whether individuals really are making free choices. In some cases, it is apparent that they are not. Therefore, almost all governments act decisively against narcotics, although many have yet to recognise the equally addictive nature of nicotine. As a result, some have failed to support effective "quit smoking" programs using nicotine replacement therapy. This may be only a matter of time. Government action against opiates is now widely accepted, but it was only 150 years ago that the United Kingdom went to war with China to protect its right to trade in opium.[8]

Addiction is only one way in which the choices of individuals are constrained. It is self-evident that behaviour is shaped by the environment. At the extremes, a person living in Mongolia has little option but to eat an unhealthy diet, dominated by animal fat and bereft of fresh vegetables. In contrast, an inhabitant of Crete may find it difficult to eat anything but a healthy diet. Similarly, an inhabitant of rural Nepal has little choice but to walk, while someone in Los Angeles may search in vain for a sidewalk. Governments can do little to change things such as climate and the topography of a country, but they can change many others, by ensuring that health is included in policies for (among others) transport, agriculture, fiscal management, and regional development, so as to remove the constraints that individuals face when making healthy choices.[9] Governments have few reservations about using these policies for other goals, including promotion of economic growth, so why not health?

Current inconsistencies in policy

Governments are often extremely inconsistent. They are willing to intervene actively in the lives of individuals to protect the health of their populations in some circumstances, but not in others. The war on terror has yet to be matched, in intensity and resources, by a war against tobacco. Governments that promote individual choice see no incongruity in their support for a small number of companies that, through their domination of the retail sector in some countries, constrain our choices about what to eat.[10]

It seems that no universal theory can explain when a state will act to safeguard the health of its population. Maybe this should not come as a surprise. Policy making is messy. Otto von Bismarck, unifier and first Chancellor of Germany, is reputed to have remarked that two things should never be made in public — laws and sausages. Policies are often a product of events (frequently following tragedies rather than pre-empting them) and interest groups, many of whom see promotion of health as a threat.[11]

The pursuit of health is as legitimate a goal for governments as national defence or economic growth. All involve balance between individual and collective interests. The challenge for public health is to advocate a greater degree of consistency than currently exists.

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References

1 National Center for Health Statistics. Health, United States, 2006. Hyattsville, Md: NCHS, 2006. http://www.cdc.gov/nchs/hus.htm (accessed Oct 2007).
2 Houston DJ, Richardson LE. Motorcycle safety and the repeal of universal helmet laws. *Am J Public Health* 2007; 97: 2063-2069.
3 Mill JS. On liberty. Harmondsworth, UK: Penguin, 1982.
4 Marx K. The eighteenth brumaire of Louis Bonaparte. In: Fernbach D, ed. Surveys from exile: political writings. Vol 2. New York, NY: Vintage Press, 1974: 143–249.
5 International Agency for Research on Cancer. Tobacco smoke and involuntary smoking. IARC monographs on the evaluation of carcinogenic risks to humans. No. 83. Lyon: IARC, 2002: 1-12.
6 Bayer R, Moreno JD. Health promotion: ethical and social dilemmas of government policy. *Health Aff (Millwood)* 1986; 5: 72-85.
7 Suhrcke M, McKee M, Stuckler D, et al. The contribution of health to the economy in the European Union. *Public Health* 2006; 120: 994-1001.
8 Hanes WT, Sanello F. The opium wars: the addiction of one empire and the corruption of another. London: Robson, 2003.
9 Ståhl T, Wismar M, Ollila O, et al. Health in all policies: prospects and potentials. Helsinki: Ministry of Health and Social Affairs, 2006.
10 Lang T, Heasman M. Food wars: the battle for mouths, minds and markets. London: Earthscan, 2004.
11 Chapman S. Advocacy for public health: a primer. *J Epidemiol Community Health* 2004; 58: 361-365.

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