

Health-Care Provision, Politics and Political Science: A Commentary

Costas G Dikeos

Department of Social Administration and Political Science, Democritus University of Thrace, Greece

Received: April 25, 2017; **Accepted:** May 04, 2017; **Published:** May 11, 2017

Introduction

Health and its provision through medical science and health-care services are usually taken for granted mostly in the wider social environment, and usually in the academic milieu. This short article wishes to explore the relationship between health-care provision policy and politics, and the importance of political science for this pursuit. Despite the methodological and epistemological importance of the issue, it confines itself in a few pages, and consists of two main sections one examining health-care provision as a political issue and one presenting the relation of health-care provision analysis to political science, closing with a third section of recapitulation and brief concluding remarks.

What Makes Health Care Provision a Top Political Issue?

Contemporary and indeed modern states often provide for a wide range of needs of their citizens and/or inhabitants. This wide range of provision may last from 'cradle to grave' and include: child-care; education and training; employment assistance; income/social security responding to incapacity to earn either due to illness, accident, disability, unemployment or old age; housing; personal social services; and indeed health-care, all of which are usually (alongside their combination and interdependence) collectively called 'social policy'. Health-care alongside social security and education is one of the 'big three' spenders in advanced welfare states such as the UK (<http://www.polity.co.uk/shortintroductions/samples/dean-sample.pdf>), whereas modern (and not only) states have (had) to spend inter alia for defence; infrastructure, energy and the environment; justice, law and order; science, research and development; heritage, civilisation and culture; etc. too. Therefore, spending for social services (to which health care is included, and has to compete with other aspects of such spending) becomes a matter of resource allocation—not to mention how high resources will be in any state or polity. This question of resource allocation (and collection) is plighted by needs assessment; demands and quests; ideology and aspirations; interests and hopes, etc. turning decision making to a cumbersome drill related to priorities that are purely political.

Focusing upon our main area of interest, health-care provision, we observe it can be set through any kind of health service,

Corresponding author: Costas G Dikeos

✉ cdikeos@socadm.duth.gr

Department of Social Administration and Political Science, Democritus University of Thrace, Greece.

Tel: ++302531039419

Citation: Dikeos CG. Health-Care Provision, Politics and Political Science: A Commentary. J Health Commun. 2017, 2:3.

while it aims at the acquisition and maintenance of 'health' or else not just at the absence of disease or infirmity, but of a sound and 'well-being' condition of dynamism assisting at happiness and the fulfilment of hopes and aspirations [1,2]. This is best pursued through the five-fold of prevention (avoidance of disease and/or illness), promotion (of a healthy and active life), therapeutic intervention (as to combat illness, mostly within hospital premises), pharmaceutical treatment (as to keep activities and abilities close to normal, mostly out of hospital but well monitored by experts), and rehabilitation (as to return to 'normal' once therapeutic intervention is over, but with some kind of ailment remaining, e.g. through physiotherapy). It should be however noted, that any kind of reaction to illness (and/or the potential reasons-causes of it) takes place in a certain social and political environment plighted by inequalities concerning living and working conditions, dietary abilities and habits, air quality, occupational hazards, knowledge about the said issues etc. (as seen in the 'Black Report', and the academic literature that followed such as the 'Widening Gap', etc.) [3-6].

Apart from, or indeed due to, its key goals and expectations, wide spectrum and inequality predicaments, health-care requires funding. Health expenditure in most advanced countries ranges from 6 to 11.5% of GDP with a significant part of it being public (may we however note that even a private share of total expenditure denotes a political decision too) as recent OECD data show [7]. Additionally, health services are among the largest employers with the UK NHS being in 2012 the fifth largest employer in

the world (some of the other four being the US armed forces, the Chinese army and companies operating internationally) [8], whereas one should add to the NHS employees, a full time equivalent number of pharmaceutical employees (often at the end of the day also funded by the national exchequer) as to acquire a better and more complete picture. Moreover, we should keep in mind that the (UK for that matter) NHS is (was some years ago) both served every day by 90,000 doctors; about 480,000 nurses, midwives, paramedics and assistants; 200,000 practice and auxiliary staff etc.; and used by 1,200,000 people [9]. It becomes crystal clear that every person is a potential user, or indeed in a most probable need to use (if available) some kind of health service (be it diagnostic, therapeutically, pharmaceutical, supportive, monitoring, rehabilitation, or whatever) at least once in his or her life. Last but not least, absence of health causes problems in lost workforce-hours and it may subsequently cause production losses [10-12].

Therefore, health-care provision is one of the few activities that combine a large spectrum of 'properties'. It affects all (even a decision not to offer or financially support health services is a political decision with certain repercussions), it costs heavily (either through public—regardless of via taxation or compulsory social insurance contribution—, or through private pay), employs many, whilst its absence has side costs too. Last but not least absence or withdrawal of health care services may lead to protests and even political unrest.

Additionally, since according to an understanding of politics based upon Lasswell's approach (and paraphrasing a little), politics is 'who takes what from whom, when and under what circumstances' [13], any kind of such activity requires argumentative political foundations (that is some form of ideological and theoretical support and legitimacy, referring to the society-state-citizen relation). It also involves a wide range of actors and stakeholders such as tax-payers, patients and potential patients (these two latter being probably the same as the former but in different roles!) and their families and associates, planners and administrators, and of course health service personnel of all levels (from experienced world class medical professors to newly appointed porters). Once examining health-care stakeholders we should add health-care technology providers (either as shareholders and executives, or as employees of pharmaceutical companies, equipment producing companies, consumables producing companies etc.). These actors and stakeholders are often (at least in modern pluralistic democracies) associated in pressure and interest groups, such as staff trade unions, medical associations, industry (con-)federations etc., each aiming to promote its members interests. Last but not least, governmental decisions are made by political parties. These decisions face critique by opposition. All parties once elected in power (or in opposition) look forward to their next election victory. In other words health-care policy is related to political-theoretical argumentation (why should a polity spend—what-resources, for—whose-health care); party politics (what do parties advocate about health-care provision vis-à-vis their general manifestoes, how and e.g. (i) regarding party politics (a) through what process

were these intra-party decisions made (?); (b) how does this affect party systems (?); (ii) regarding interest groups politics (c) what is the role of physicians' trades unions, patients associations, pharmaceutical companies federations (?); (d) how do they gain positive outcomes for their members (?); etc.

It is for these reasons that health-care provision is seen by this short commentary as a top political issue, whereas followers of British politics know that it often becomes a key political argument in an election (or indeed in the 2016 'Brexit' referendum). Coupling political science approaches the historical evolution and development of these services should be always kept in mind [13-15].

Last but not least such a pursuit requires the mobilisation and use of vast resources (human, durable, perishable, and non-material and other) via top-rate planning, directing, administering, monitoring and controlling, in other words by implementation of sound management an issue that, however important, remains out of the focus of this very paper.

After referring to issues that relate health-care provision to political issues, the remainder of this article will now on (II) turn upon, questions and methods that relate health-care studies to political science.

Political Science and the Study of Health-Care Services Provision

As argued above in section I, health care provision policy involves both political argumentation and process that is often confrontational and adversarial. Put another way, policy regarding health care provision, its scope and number of people covered is the outcome of implementation of political ideas and political theory, and of confrontations, conflicts or coalitions within a polity (or else 'politics') be they aiming at decisions, or regarding implementation once decisions launched into action and practice. Reference should be also made to the importance of the international environment either as a framework for the setting of domestic policies, or as a domain of assistance policies especially for the non-developed world, a research area also out of focuses of this article, however political.

Therefore, it is not only that health care provision is a key or else top political issue, it is that it can and in this article's view also should be approached and analysed through the view and by the use of methods and tools of political science.

A publicly funded (either through taxation or through compulsory state administrated and if needed supported social insurance) national health-care service free at the point of delivery that is accessible to all can be both claimed through, and supported by a wide range of political theory postulations, occasionally conflicting each other, thus making us seem eclectic. Obviously such theories can be confronted and juxtaposed by other ones, not to mention approaches just analysing the functional need and contradictions of (publicly funded expensive) health care provision, a fact at the end of the day strengthening the argument about the close relation between health-care provision and political theory.

It is out of reach of a short commentary to provide a full, detailed and in-depth presentation and analysis of all political theory(-ies) in relation to health-care policy, something also attempted by Kennedy and Kennedy [16]. We will therefore contain ourselves in brief references rather to arguments than to theorists and books.

Turning to theories that can explain the functional necessity of some kind of intervention as to maintain productivity by keeping workforce healthy enough as to (re-)turn to the workplace, an idea based upon Marx's [17] theory of labour and explored by the so called 'German derivation school' and 'capital logic school' that were prevalent in the late 1980's early 1990's [16,18], with remarks over contradictions between capitalism and the welfare state [19]. Political theory and political philosophy (alongside social theory and social philosophy) cutting through and proposing the individual-society-state-economy relations can be used (occasionally turning to ideologies and even party ideologies) to assist claims for the formation and sustaining of well-funded health-care services as the work of Vic George [20] has shown, or an exploration of Aristotle, More, Rousseau, Mill, Marshal, and Rawls among others may indicate. On the other hand political theory (other theorists) can be used indeed to counter and juxtapose arguments and contrary propose the need (alongside the positive repercussions of absence of such a publicly funded health service, and negative of its implementation as regards to individual freedom) to avoid or even annul if previously implemented of such a policy, as the work of Hayek, Buchanan, Freedman, and other 'New Right' theorists has demonstrated (occasionally also turning to ideology and party ideology indeed). It is obvious that neither list of theories and theorists is complete, full and exclusive of additions, and that both are indicative as to support our argument about the key relation between political theory and political philosophy (that are acknowledged as key components and elements of political science) and health-care provision and its academic study, examination and analysis**.

Similarly, comparatives approaches can be used to group government choices with political party ideologies and explore whether socialist, social democratic, conservative, liberal and neo-liberal parties perform differently to each other regarding health-care (or even suggest different manifestoes) in analyses in a cross state level. In this case the question becomes if (according to a hypothesis) socialist and social-democratic parties and governments spend more, provide wider access to and of services than conservative and neo-liberal ones, an issue that can be explored via comparisons of the private/public expenditure mix, legislation, etc. seeking the relation between political parties, party politics and health care financing and provision via the scope of political ideology, party functions and representation at a level of liberalism, social democracy, conservatism etc. Such an approach, though using similar (or even the same) terminology as the one by Esping-Andersen [21], alongside the vast and very important social policy literature that followed regarding Conservative, Liberal and Social Democratic welfare regimes differs as it focuses upon political parties***. It should not be seen though as to confront the 'welfare regimes' approach but

rather to compliment it by adding further problematiques such as political parties, party politics and political and party systems (e.g. Mair) to the realm of health care (and social policy more broadly) analysis*. Obviously, health care policy can be analysed through the examination of party politics not only on cross-state level, but within individual countries too regarding different government periods (e.g. the current -2017- developments in the USA and the attempts of the Trump administration to change 'Obamacare'). Having noted that, we can refer to broader welfare issues also, and to relate it not just to party politics, but to party ideologies too, thinking of the Cameron leadership period of the Conservative Party and the 'Big Society' discourse versus welfare policies, as depicted in Taylor-Gooby and Stocker [22].

Additionally, health-care policy provision can be approached (especially regarding its day to day implementation and function) as the outcome of pressure groups actions using a pluralistic methodology.

Brief Concluding Remarks

This short article wishes to demonstrate, however briefly and through a first glance the key questions of whether health care provision is a political issue, and whether it can and should be approached via political science. It claims that health care regards all population members as potential users, costs expensively, employs many and operates within a social environment of inequalities, whilst its absence may cause problems at least in production, but in political tranquillity too. It is for these reasons that health-care provision is a political issue. On the other hand being a political issue, health-care provision policy can and should be analysed by the use of political theory, political sociology, comparative politics, etc., all of which are parts of political science. Having claimed that, the article does not wish either to exclude other approaches to health-care provision policy (e.g. through economics, fiscal studies, sociology, law, history, management etc.), but rather to invite to a productive academic dialogue. Neither does it wish to contain political science to the study of health-care services, as it can be used for the approach of all other state (and indeed social welfare state) actions to be they education, pensions, employment, child care etc., alongside broader issues such as defence, infrastructure, development, or whatever else concerns societies and polities. It additionally does not confine, but it rather encourages and invites political scientists interested and dealing with health-care provision policy to explore more aspects of political science such as political theory, party politics, comparative politics, alongside history of welfare as to show how we got where we currently are etc. It is just aiming to emphasise that health care is due to reasons approached one of the key concerns of polities, therefore a key political issue, and political science can be used as one of the ways to analyse health-care provision.

Note: *These volumes are collections of various articles and chapters; individual chapters from the volumes have been also read [23,24]. As they have however significantly assisted

in forming the arguments set in the paper, but not been directly quoted and the paper wishes to be a short commentary, we choose to refer only to the wider volumes, not to overload the reader.

**As with the previous note above, we think it is neither helpful, nor necessary to include to the bibliography all references

to the work of the theorists mentioned as no direct use of their work has been made. Easily we could cherry pick and refer to Aristotle's Politics, More Utopia, Mill's On Liberty and Utilitarianism, Rousseau's Social Contract, Hayek's Constitution of Liberty, Freedman's Free to Choose etc. Also regarding the Esping-Andersen approach the literature that followed is vast including collective volumes [25].

References

- 1 <http://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf>
- 2 http://www.who.int/bulletin/bulletin_board/83/ustun11051/en/
- 3 Black, Douglas; "Report, of the Working Group on Inequalities in Health" (Known as 'The Black Report') in Townsend, Peter, and Nick Davidson and Whitehead Margaret 1988.
- 4 Gordon D, Shaw M, Dorling D, Davey-Smith G (1999) *Inequalities in health policy* press. University of Bristol, Bristol, USA.
- 5 Shaw Mary, Dorling Daniel, Gordon David, & Davey Smith George (1999): *the Widening Gap*, Policy Press, University of Bristol, Bristol.
- 6 Babones Salvatore (ed) (2009) *Social Inequality and Public Health*, Policy Press, University of Bristol, Bristol (*).
- 7 http://www.keepeek.com/Digital-Asset-Management/oecd/social-issues-migration-health/health-at-a-glance-europe-2016/health-expenditure-in-relation-to-gdp_health_glance_eur-2016-34-en#page3
- 8 <http://www.telegraph.co.uk/news/uknews/9155130/NHS-is-fifth-biggest-employer-in-world.html>
- 9 Pascall G (2003) *Health and health policy*. In: Badlock J, Manning N, Vickerstaff S (eds.) *Social Policy*, Oxford University Press, Oxford, USA.
- 10 <http://mrc-catalogue.warwick.ac.uk/records/CBI/Z/O/1/407>
- 11 Lock J (1975) "Cost of safety in the workplace" *Employment Gazette*, HMSO: London pp: 19.
- 12 Dikeos KG (1992) *Capitalist relations and state policy: the development of the mode of health maintenance in contemporary Britain 1948-89: a case study*. Unpublished PhD Thesis, the University of Edinburgh.
- 13 Almond, Gabriel A: "Harold Dwight Lasswell 1902—1978 A Biographical Memoir, National Academy of Sciences Washington D.C, 1987, in <http://www.nasonline.org/publications/biographical-memoirs/memoir-pdfs/lasswell-harold.pdf> visited 5 April 2017.
- 14 Brian Abel-Smith (1964) "The Hospitals 1800-1948 A Study in Social Administration in England and Wales" Heinemann London.
- 15 Fraser, Derek (2003), *The Evolution of the British Welfare State*, Palgrave Macmillan ed. Houndmills.
- 16 <http://press.uchicago.edu/ucp/books/book/distributed/U/bo13441041.html>
- 17 <https://www.marxists.org/archive/marx/works/download/pdf/Capital-Volume-III.pdf>, <https://www.marxists.org/archive/marx/works/download/pdf/Capital-Volume-I.pdf>
- 18 <https://libcom.org/library/state-capital-marxist-debate-john-holloway-sol-picciotto>
- 19 <https://mitpress.mit.edu/books/contradictions-welfare-state>
- 20 <http://press.uchicago.edu/ucp/books/book/distributed/M/bo13438553.html>
- 21 Esping-Andersen G (1990): "The three worlds of welfare capitalism". Polity Press Cambridge, UK.
- 22 Peter Taylor-Gooby, Stocker Gerry: *The coalition programme: a new vision for Britain or politics as usual? The Political Quarterly* 82: 1.
- 23 Dubowitz Tamara, Ospuk Theresa & Kurland Kristen: *Examination of the Built Environment and Prevalence of Obesity: neighbourhood characteristics, food purchasing venues, green space and distribution of body Mass Index*; in Babones Salvatore (ed) *Social Inequality and Public Health*, Policy Press, University of Bristol, Bristol.
- 24 Sartori G (1990) *A typology of party systems*. In: Mair P (ed.) *The western European party system*.
- 25 Petmesidou M, Mossialos E (2006) *Social policy developments in Greece*. Aldershot: Ashgate.