

Chapter 1

Introduction

STORIES OF public health are stories about how individuals, communities, and states recognize and respond to the threat of disease. These stories have a dramatic form. Actors—experts, officials, aroused citizens—emerge on the public stage in the first scene, sounding the alarm and demanding action to contain some perceived threat. As the action proceeds, the threat is defined and redefined, its reality contested, and its source disputed. In subsequent scenes, public authorities may or may not respond. Citizens may or may not take matters into their own hands. Dramatic resolution may or may not be achieved. The public's health may or may not be advanced. Tension and struggle—conflicts of power, interest, and ideology—are the hallmarks of the public health drama, just as they are the hallmarks of any circumstance that pits one set of powerful interests, however nobly defined, against another (there is, almost always, another). Dramas of public health presented in narrative form are the raw material for this book. Its subject is the analysis and interpretation of these dramas as forms of struggle for social change.

I define public health as “community action to avoid disease and other threats to the health and welfare of individuals and the community at large” (Duffy 1990, 1). The critical phrases in this definition are “community action”—public health is society's collective response to a perceived common threat—and “avoid disease.” This is a book about the vicissitudes of societies' collective struggles to avoid disease. It is not about health-care policy as this phrase is commonly used, to mean policies for the provision of medical care to individuals already ill. Nor is the scope limited to the formal structures in which public health is embodied: health ministries, local health departments, designated public health officials. Action to prevent disease takes many forms, ranging from the charismatic individual on the corner handing out clean needles to injection drug users, through the lawyer spearheading a class action suit against the tobacco industry, to the parliamentary debate pitting proponents of disease prevention against opposing economic and moral interests. Public health policies include

any public or publicly advocated policy—ranging from immunization to income redistribution—intended in whole or in part to improve health or prevent disease.

Public health is inherently political. Attributions of disease causation are statements about the location of responsibility for human pain and suffering and, by the same token, about the measures that should be taken to prevent these maladies from occurring. Major sources of variation in these measures are the extent of their challenge to the existing social order and the degree to which they invoke the power of the state. Witness, for example, the nature of debate about the causes of tuberculosis at the beginning of the twentieth century in France (Barnes 1995). The monarchist right gave its etiological preference to the irresponsible and immoral drinking habits of the working class and resisted social reform. Socialists attributed it to unsanitary housing and exposure to the newly recognized tubercle bacillus, downplayed alcoholism, and demanded parliamentary attention to poverty as the ultimate cause. The increasingly influential revolutionary syndicalists rejected mainstream causal theories altogether. Tuberculosis, they maintained, was “inherent in the logic of capitalism.” Medical prescriptions, clinics, and sanatoriums were scams intended to deflect real reform and sop the conscience of the “compassionate elite.” Defeating tuberculosis required overthrowing the capitalist system. Although this may be an extreme (or just an unusually clear) case, remarkably parallel political commitments continue to be at least implicit, and often explicit, in current intellectual as well as policy debates on disease causation and the role of public health.

The public health stories I have selected to relate and to analyze are infant mortality and tuberculosis at the turn of the nineteenth century and the contemporary dramas of cigarette smoking and HIV/AIDS in injection drug users. The narratives in the first part of this book describe how each of four countries—the United States, Canada, Britain, and France—experienced and responded to these common threats to their publics’ health. The goals of the analysis in the second part are to arrive at an understanding of the social and political processes that drive policy making in public health and to explain why countries otherwise comparable in so many respects reacted differently to essentially the same threats.

Background

The idea of public health emerged in Britain and France in the first half of the nineteenth century. It grew from the increased concern of a few physicians and public officials about the devastating health, economic, social, and potential political consequences of urbanization and industrialization, particularly among the urban poor. Its principal investigative tool was

the social survey. Its dominant theories were environmental. The unique domain of this new discipline and set of activities was disease as a product of the environment, not sick individuals (who were in the domain of curative medicine).

Nineteenth-century hygienists emphasized the social and material environments in which disease developed and advocated both sanitary and social reform as the most effective public health measures. (La Berge 1992, 74)

Public health was linked with social reform because disease was attributed to social conditions—from poverty to inadequate sewers and water supply—that, advocates maintained, called for state action. Attention to working class misery and deprivation was triggered in part by labor and social unrest, and public health was advocated as an alternative to social revolution. Referring to the United States, Fee observes:

Politically, public health reform offered a middle ground between the cut-throat principles of entrepreneurial capitalism and the revolutionary ideas of the socialists, anarchists, and utopian visionaries. [Speaking in 1892, William H. Welch suggested that] sanitary improvement offered the best way of improving the lot of the poor, short of the radical restructuring of society. (1991, 5)

Even during the heyday of environmental theories of disease causation in the nineteenth century, the idea of public health as a rationale for social reform was by no means universally accepted. Advocates confronted ideological opposition to state intervention on behalf of public health—opposition was especially strong in France—as well as ratepayer reluctance to pay for expensive water and sewer projects. And they confronted competing theories—theories of private health—that laid unsanitary conditions, poor health, and excess mortality at the door of the poor themselves: the inevitable consequences of immorality and intemperance. Although the relative salience of each of these strands in opposition to the idea of public health as social reform varied across countries, they were never wholly absent.

The idea of public health as social reform receded in the course of the late nineteenth and early twentieth centuries in the face of new theories of disease causation, shifting attributions of responsibility for disease prevention, and changes in the structure of medical care. The germ theory “drew attention away from the larger and more diffuse problems of water supplies, street cleaning, housing reform, and the living conditions of the poor” (Fee 1991, 7). A “direct appeal from mortality figures to social reform [became] much more difficult” (Lewis 1986, 6). The displacement of social and environmental reform by the control of specific diseases as the preferred solution to public health problems was most noticeable in the United

States. But the accompanying emphasis on individual responsibility—in particular, the responsibility of mothers for the health of children and families—was widespread (Tomes 1990; Klaus 1993; Lewis 1980; Dwork 1987; Meckel 1990).

The exigencies of world wars and depression, though they put new life into the idea of collective *responsibility* for health, failed to revive the idea of public health as social reform. Health was defined as a characteristic of individuals, not of social or physical environments, and health reform became defined as the institution of state-supported arrangements for universal access to individual medical care. Negotiation with respect to the details of these arrangements (or, in the United States, their rejection) was dominated by physicians committed to the individual doctor-patient relationship as the linchpin of population health. In direct confrontation between medical and public health doctors—even in Britain, home to the earliest and best organized corps of local public health officers—public health was hopelessly overmatched (Lewis 1986).

If the idea of public health as a vehicle for societal-level social change had not already disappeared from the ideological armamentarium of the public health establishment, its death knell was sounded in the early 1970s with the popularization of risky lifestyles as the major determinant of disease in the developed world. The risky lifestyle framework—embraced most wholeheartedly in the United States—located both the source of disease and the means of prevention within the individual. Carried to its extreme, this ideology—for ideology it is—relieves the collectivity of any responsibility for population health.

These implications have, of course, been widely contested—from, however, different perspectives in the four countries. And the idea of public health and disease prevention as vehicles for broad social reform has not, in fact, disappeared. The flame has been kept alight by actors, few of whom are public health professionals or even think of their activities as within the domain of public health.

Premises

This book has three premises. The first is that public policies in general, and public health policies in particular, play a critical role in disease prevention and in the decline of mortality. This premise is hardly self-evident. The ideological conflicts described are mirrored in intellectual debate among theories that assign causal priority in accounting for disease prevention to economic development or advances in medical technology and more socially activist theories that emphasize the role of (broadly defined) public health policies and of the social and political context in which they emerge. This debate has generated controversy among scholars for at least the last quarter century.

The debate was initiated in a series of publications by the British epidemiologist Thomas McKeown beginning in the 1950s (McKeown and Brown 1955; McKeown 1965, 1976; McKeown, Record, and Turner 1975). McKeown based his analyses on nineteenth- and twentieth-century mortality declines in England and Wales. Although he did not discount public health altogether, McKeown's principal argument, and the one for which he is most often cited, was that mortality decline was specifically not caused by doctors and hospitals, drugs and therapies, but was the result of an improved standard of living. His thesis left little room for active human agency in the improvement of population health.¹

Although McKeown's rejection of medical technology is widely accepted, his proposed alternative is not (see, for example, Colgrove 2002). The idea that some combination of greater income and wealth with improved nutrition is responsible for mortality decline has been contested both by British scholars using data from England and Wales (Szreter 1988, 1997; McFarlane 1989; Hardy 1993) and, more broadly, by American scholars, principally Samuel Preston, based on analyses of data from the United States in the first years of the twentieth century and of more recent data from developing countries (Preston 1975, 1985, 1996; Preston and Haines 1991). I summarize these scholars' conclusions in their own words:

My argument is not that improving nutrition and living standards were entirely unimportant in accounting for the mortality decline (in England and Wales), but that the role of a battling public health ideology, politics and medicine operating of necessity through local government, is more correctly seen as the causal agency involved. (Szreter 1988, 36)

In a later piece on the same theme, Szreter continues:

A favourable outcome [of economic growth] was in no way inevitable. It had to be devised with the aid of medical science *and fought for politically*. (1997, 696, emphasis added)

Preston makes much the same case for the United States:

this explanation [of mortality decline] emphasizes a fundamental scientific advance, the germ theory, as implemented by public health officials and, perhaps more importantly, aggressively disseminated by them to an extremely eager audience. (1996, 7)

New analyses of the role played by clean water technologies (that is, water filtration and chlorination) in late nineteenth- and early twentieth-century mortality decline in the United States lend strong support to Preston's and Szreter's conclusions: "clean water was responsible for nearly half the total

mortality reduction in major cities, three-quarters of the infant mortality reduction, and nearly two-thirds of the child mortality reduction" (Cutler and Miller 2005, 1). Clean water did not, of course, happen automatically. As with most public health reforms, it had to be fought for politically (Szreter 1988, 1997; Troesken 2004).

Two critical points are contained in these observations. The first, consistent with my initial premise, is that organized human agency as represented by the public health movement has been instrumental in the decline of mortality. I will reexamine that premise in the book's conclusion in light of information from the sixteen country and issue case studies that form the body of my text.

The second point—that this movement reflected social and political developments independent of changes in per capita income—serves to introduce my second premise, that the formation, adoption, and implementation of public health policies are the outcome of social and political processes. These processes were elaborated in the 1980s by demographers working principally in developing country settings (for example, Nag 1985; Palloni 1985; Caldwell 1986; Johansson and Mosk 1987) and by comparative sociologists interested in the determinants of social policies in industrialized countries (Orloff and Skocpol 1984; Skocpol and Amenta 1986). The consensus among these scholars was remarkable. The variables they identified—the characteristics of states and the collective actions of citizens—are central in my conceptual approach to unraveling the politics of public health.

The demographers cited used alternative strategies to determine the causes of mortality decline: comparison of developing countries similar in their income and wealth but with unusually high or low mortality levels, and comparison of industrialized countries with similar mortality levels but—in the late nineteenth century—very different social and economic characteristics. These studies concluded, first, that unexpectedly "low" mortality countries were distinguished by widely distributed public health services (for example, sanitation, immunization, maternal and child health) and, second, that widely distributed public health services resulted, in turn, either from the actions of a strong central government with a reasonably well-educated and cooperative population, or from an organized, politically active population with a reasonably responsive central government.

Along similar lines, Skocpol and colleagues argued that social provision (for example, old-age pensions, health insurance, compulsory unemployment insurance) by industrialized countries cannot be explained by these countries' relative economic growth or their levels of industrialization and urbanization. In common with several of the demographers I have cited, these investigators emphasized "the organizational structures and capacities of states" (Skocpol and Amenta 1986, 147) and,

in later work, “the institutional leverage that various social groups have gained, or failed to gain,” as the principal shapers of social policy making (Skocpol 1995a, 19).

Comparative demographic research focused primarily on declines in mortality from communicable disease; the public policies at issue were traditional public health policies, clean water, sanitation, immunization, and the like. Public policies are, however, equally relevant to what we may now perceive as the more clear and present dangers of tobacco smoke, breast cancer, HIV/AIDS, and environmental pollution.² Changes in public policies to mitigate these dangers come about in large part—if not wholly—through the actions of governments, initiated internally or in response to external popular and political pressure.

Convergence among medical historians, demographers, and comparative sociologists on the importance of government-initiated public policies in the decline of mortality has had little noticeable impact on empirical social research on public health policies or on the conceptual development necessary to guide this research—in part, perhaps, because of a belief that political analysis is not science (see for example, Newman 1999, 279, McKinlay and Marceau 2000, 51). And so, though there is recent recognition, particularly among scholars of public health law, that policies—for example, “[drug laws] and the police practices flowing from them”—are structural factors that influence health (Burris, Strathdee, and Vernick 2003, 881), macro-level theory to guide the identification and analysis of these factors is conspicuous by its absence. As a result, little attention has been paid to specifying the social and political processes that push policy makers toward or away from particular public health policies or shape their implementation. To make change in social policies, the first step must be to understand how these policies came about.

My last premise is methodological: the best strategy to identify the social and political processes that drive change in public health policies is by cross-national comparison. This project is a case-comparative study in the methodological tradition of illustrious forebears past and present, including Max Weber in *The Protestant Ethic and the Spirit of Capitalism* (1904/1949), Barrington Moore in *Social Origins of Dictatorship and Democracy* (1993), Theda Skocpol in *States and Social Revolutions* (1979), and Charles Tilly (whose works are too numerous to list). I mention these scholars not to appropriate their luster but to situate my own more modest effort in a particular methodological fold within sociology, that of case-comparative research (see, for example, Ragin 1987; Ragin and Becker 1992; Mahoney 2004). The advantages of this method for present purposes are that it combines historical specificity—the location of actions and events in specific times and places—with the potential for theoretical generalization.

Selecting Countries and Public Health Issues

The units of analysis for this project—the cases—are sixteen country-and-issue combinations: four countries and four public health issues. I explain my selection of countries and issues below, but let me begin with a reality check: in the practice of case-comparative research “cases are chosen for all sorts of reasons, from convenience and familiarity to fascination and strategy” (Walton 1992, 125). In no sense are these sixteen cases a random sample of countries or of public health issues, nor do I claim that the issues selected are typical of public health issues these four countries faced over the past hundred or so years. My reasons for the selections I made were both pragmatic—convenience, familiarity, and fascination—and strategic in that I attempted to maximize the probability that the social processes in which I was interested—the politics of public health—would be laid bare. In his remarks, Walton went on to say that cases once chosen—for whatever reasons—must be “shown to be a case of something important” (125). I will later return to the questions Walton’s observation suggests: what my sixteen cases are cases of and why they are important.

When I embarked on this project, my primary interest was in the social and political dimensions of public health policy making in the contemporary United States. I soon became aware that some of the same public health issues agitating citizens and policy makers in the United States—environmental pollution, smoking, HIV/AIDS—were of equally deep concern in other countries, and that substantial leverage in understanding the American experience might be gained by cross-national comparison. Further, though important comparative work on these issues has been undertaken by scholars from a variety of disciplines, the literature offers little or no systematic cross-national comparative research on the sociology and politics of public health more broadly, in contrast to the large body of comparative research on systems of medical care.³

Selecting Countries

I selected Britain, Canada, and France to maximize the leverage from the proposed comparison with the United States. First, these countries are similar in many of the characteristics that might be expected to shape the responses of states to public health problems: the depth and sophistication of their medical and scientific establishments, their economic and political systems, and their economic affluence. Second, though their roles may vary, the actors in the public health drama—physicians, politicians, administrators, advocates of one stripe or another—are essentially the same. Third, these countries were nonetheless quite dissimilar in the timing and character of their response to the public health dangers I have identified. It was not until 1963, for example, that France made tuberculosis

reporting mandatory, whereas in New York City reporting was made mandatory in 1897 (with other U.S. municipalities quickly following suit), and in Britain in 1913. Conversely, needle-exchange programs to protect injection drug users from HIV transmission were established in Britain in 1988 with state sponsorship and funding. In the United States, on the other hand, federal funding and sponsorship for these programs have been explicitly rejected and many programs remain underground for fear of police and legal harassment. Not only, then, do these countries react with varying degrees of aggressiveness to the *same* threat, but also there is a good deal of inconsistency in how the same country responds to *different* threats.

In addition to cross-national variation, there is substantial variation within each of these countries in the allocation of formal responsibility for public health between local, regional, and national authorities. I deal with this potential problem by treating the genesis of attention to public health threats and the allocation (or assumption) of responsibility for responding to these threats as empirical questions, not as given by the formal location of responsibility for public health. Starting with an identified public health problem, I trace the major actors regardless of their geographical, bureaucratic, or political location. This location is highly variable across issues, across countries, and across time. For example, in all four countries at the turn of the last century, local public health, medical, and civil authorities played important roles in public health action against tuberculosis and infant mortality. Infant mortality was unique, however, in capturing the attention of the state and of organized women's groups acting nationally as well as at a local level. More recently, predominantly lay grassroots organizations played major roles in the initial response to smoking in the United States but were much less important in Britain and France. These variations result from differences in how the problem is brought to public attention (whether by physicians, civil servants, aggrieved citizens, or someone else), in the location of political power (who is perceived as having authority to do something about the problem), and in citizens' expectations and beliefs concerning the political level at which action should be taken in response to a problem in public health.

Selection of Issues

My choice of public health issues—tuberculosis and infant mortality at the turn of the nineteenth century and, currently, smoking and HIV/AIDS in injection drug users—was driven initially by their public health importance. I measured importance not only by an objective standard—all are major causes of illness and death—but also by the level of medical, public, and policy attention these issues received at the time they emerged on the public stage. Arguably, the sociology and politics of public health are illuminated as much by the problems that are ignored as by those that are

engaged. However, apart from the practical obstacles to investigation of problems that failed altogether to attract expert or public attention, the trajectory of issue salience is uneven, so that even dangers highly salient at one time may be largely ignored at another, regardless of their magnitude as reflected in incidence or prevalence rates.

Social movements and other forms of action organized around perceived threats to the life and health of individuals, communities, the nation, even the planet, have been a prominent feature of American life since early in the twentieth century. Recently, cigarette smoking, AIDS, abortion, black lung disease, nuclear power, air and water pollution, breast cancer, drunk driving, and a host of other perceived dangers have engaged politicians and public officials in the United States and have served as catalysts for the formation of groups to challenge accepted definitions of these issues and to demand redress. However, relatively few of these issues received comparable levels of policy or public attention (or both) in more than one or two of the other three countries. A major consideration in the selection of cigarette smoking and HIV/AIDS was that they emerged as significant public health problems in all four countries at about the same time. Each country entered the starting gate with more or less equal inexperience in coping with these particular issues. It was reasonable to anticipate that how they coped would shed light on the social and political processes in which I was most interested (processes I will spell out in the following section).

Cigarette smoking and HIV/AIDS proved, in fact, to be ideal candidates for revealing the roles of ideology and politics in public health. A wide range of actors and forms of action were mobilized in response to these issues, and substantial controversy was generated around the meanings of these problems and how and by whom they should be addressed. Further, it required no more than cursory reading of these countries' national press to become aware of the profound differences between the United States and Canada, Britain, and France in how and by whom these issues were portrayed and addressed. These differences argued strongly for the potential of comparative research to illuminate U.S. policies (and, of course, the policies of these other countries as well). Finally, within the larger problem of HIV/AIDS, I elected to focus on the threat to injection drug users. Although drug users were, in fact, an important part of the AIDS epidemic from the beginning, they have been relatively neglected in the vast literature on the social, political, and ideological dimensions of HIV/AIDS. Further, narcotic drug use is equally stigmatized in all four countries, so that differences in countries' response to the AIDS-drugs nexus could not be attributed to differences in the level of stigma.

To fully understand a country's present public health policies it is essential to know something about its policies in the past. Countries display a substantial degree of continuity across time in their policy-making

styles, and attention to the reasons for this continuity is critical to the analysis of policy decisions. By the late nineteenth century, tuberculosis and infant mortality had emerged as significant public health problems in all four countries, and I chose them primarily for that reason. My narratives are cut off at approximately the beginning of World War I not because these conditions were no longer important but to limit the task of reconstruction to a reasonable compass.

Additional reasons emerged in the course of research. Most obvious, perhaps, are the parallels between cigarette smoking and drug injection. Both nicotine and heroin are substances with long histories of medicinal as well as recreational use, and both have moved back and forth over time between the categories of innocuous pleasure and dangerous drug (Berridge and Edwards 1981; Berridge 1997; Goodman 1998). As drugs, however, they carry very different social and cultural baggage, which makes for illuminating comparisons in their treatment within and across countries, both now and in the past. The late nineteenth- and early twentieth-century response to infant mortality is of unique interest because of the degree to which infant mortality was identified with the state and mobilized its energies. Comparison of infant mortality with other public health issues, within countries, across countries, and across time illuminates in particular the circumstances in which states are more or less likely to expend their political capital on public health.

In my selection of cases I have clearly privileged contest and struggle over routine. There are two reasons for this. First is the problem of cross-national comparability. Many routine activities that are considered public health services in the United States—for example, breast cancer screening for poor women—are individual health services in the other countries, provided through their national health-care systems and thus not within the purview of this project. Second, and much more important, the politics of uncontested public health activities were likely to be both well hidden and not terribly revealing about the social and political processes that are the subject of this book.

Casing the Cases

What, then, are my sixteen cases cases of? At the most abstract level, they are cases of struggle over the definition and ownership of public problems (see, for example, Gusfield 1981) and over the power to occupy and dominate the terrain that those problems are claimed to represent. As I pointed out earlier, the cast of characters in these struggles has been remarkably constant across space and time. Their relative success is powerfully shaped by social and political contexts that tend to privilege one category of actors over another, creating the differences in “institutional leverage” that move social policy in one direction or another (Skocpol 1995a). At a

slightly less abstract level, each case pits social reformers (who come in many guises, as we shall see) against institutions, groups, and individuals who oppose reform—or at least reform as reformers interpret it. By comparing these cases, mostly across countries but occasionally within a single country, I hope not only to comprehend the particularities of each case—to understand how countries arrive at one set of policies rather than another—but also to build a body of empirical evidence sufficient to support theoretical as well as empirical generalization across cases.

States, Collective Action, and Constructions of Risk

I argued above that specification of the social and political processes that drive policy making in public health is hindered by an absence of macro-level theory to guide identification and analysis of these processes. The volume of data potentially relevant to specification of these processes is enormous. The initial theoretical notions with which I approached this project had two purposes. First, to thread my way through the mass of potentially relevant information, I needed a conceptual map that would tell me—at least preliminarily—where to look and how to sort through the data I accumulated. Second, given my goal of generalization across cases, I needed a set of concepts sufficiently abstract to be applicable to all sixteen country and issue combinations. I developed a conceptual map grounded in work of the demographers and comparative sociologists cited earlier (for a preliminary version, see Nathanson 1996). It has three broad, decidedly macro-level elements: the organization and interests of nation-states, social movements and other forms of collective action outside the state, and ideologies that frame constructions of risk to health. I now briefly introduce each of these elements (for more conceptual detail, analysis, and interpretation, see chapters 7 to 9).

Nation-States

Public policy is powerfully shaped by the actions of nation-states. This assertion—central to the arguments of the scholars cited earlier—sounds like a truism when baldly stated. Nevertheless, the concept of the state as an autonomous actor is of relatively recent vintage in the work of comparative social scientists (see, for example, Evans, Rueschemeyer, and Skocpol 1985). This concept—along with the idea of systematic national variation in what John Peter Nettl called stateness and what later came to be called state strength—was proposed in an influential paper published in 1968 (1968). Nettl's ideas have been elaborated—and critiqued—ever since in publications too numerous to mention. Coming in for particular opprobrium have been “gross characterizations of ‘strong’ versus ‘weak’ states” (Evans, Rueschemeyer, and Skocpol 1985, 360). Nevertheless, I

have found these characterizations valuable in at least two respects: first, as a reminder to collect ample data on the words and actions of the civil servants, politicians, and other government officials who embody the state in all but its most mythical sense; and second, as a heuristic device, raising questions about why putatively strong states do not act when action seems required and weak states sometimes do. I employ the strong state–weak state dichotomy (explicated briefly below and more fully in chapter 7) as an ideal-type—a logical construct against which empirical reality may be compared (Gerth and Mills 1946).⁴ This construct is at best descriptive and in no way explanatory, as the materials that follow will show. It has not been superseded by other and better conceptualizations of state variation, however. Its liveliness is demonstrated by its continuing status as a whipping post for historians and political scientists (for example, Baldwin 2005b).

Adopting the conceptual perspective of Skocpol and other students of social policy, I conceive of nation-states as autonomous actors that “may formulate and pursue goals that are not simply reflective of the demands or interests of social groups, classes, or society” (Skocpol 1985, 9). Weak states are “those unable to formulate policy goals independent of particular groups in their society, to change the behavior of specific groups, or to alter directly the structure of their society—and strong states . . . are able to accomplish each of these objectives” (Vogel 1986, 265). In the ideal typical case, strong states are notable for their capacity to act. Structural characteristics thought to contribute to this capacity are centralization (that is, a unitary rather than a federal structure), concentration of power in the executive branch of government (as opposed to separation of powers, as in the United States), and the presence in the state of politically independent “career officials relatively insulated from ties to currently dominant socioeconomic interests” (Skocpol 1985, 9). In the ideal typical case, officials in a strong state make policy based on their judgment of the greater good, largely insulated from the pressure of private interests (that is, civil society).

Policy innovation and policy implementation may be responsive to different state characteristics. Administrative and financial centralization and government officials’ decision-making autonomy (defining characteristics of strong states as noted earlier) are widely held to facilitate implementation. In the ideal typical strong state, execution should go smoothly once policy decisions are made. By the same token, “a complicated division of jurisdiction between a multitude of semi-independent government agencies and a federal stratification of state authority [as in the United States] tends to make policy implementation more cumbersome” (Kitschelt 1986, 63).

States not only are policy actors in their own right but also play a major role in conditioning the opportunities for collective action available to

groups outside the formal political and administrative structure (Immergut 1992; Skocpol 1985; Tarrow 1998). Indeed, limits placed on access to policy making by groups outside the formal state structure are a defining characteristic of the ideal typical strong state (Hall 1986; Vogel 1986).

I illustrate the concept of strong and weak states as well as the limitations of this concept for explanatory purposes with a capsule summary of my observations on public health policy making in France and the United States, paradigmatic examples of strong and weak states. If, indeed, strong states were more able policy makers (as I had initially—perhaps naively—hypothesized) then France should have been in the vanguard of action to protect the public's health.

France is a unitary state characterized by cohesion between the executive and legislative branches of government; insulation from the demands of other social actors, such that policy initiatives tend to come from within the state itself; the capacity to implement policy over the demands of other social groups; and an ideological identification of the state with the public interest (Hall 1986; Dobbin 1994). The United States presents a clear contrast, both institutional (as reflected in the separation of powers within the federal government and between the federal government and the states), and ideological, as we are constantly reminded by advocates for the devolution of power from the center to state and local governments. Comparison of these two nations' public health policy making, however, suggests that state strength is as likely to be associated with state paralysis as with effective action. The delayed French response to tuberculosis at the turn of the nineteenth century and more recently to HIV/AIDS can be explained in part by state inaction combined with a weak tradition of local action on the ground. In the United States, on the other hand, relatively weak federal responses to the public health problems presented by cigarettes and by HIV among injection drug users were offset (far more so in the former case than in the latter) by energetic action at the local level. Under circumstances where the central state is unable or unwilling to act, institutional and ideological commitment to centralized power may have the effect of inhibiting *any* action, whereas decentralization may offer a wider range of opportunities.

More generally, I argue in this book that differences among states in how public health policies are made, albeit systematic, are not straightforwardly predictable from their degree of strength or weakness. My research does suggest that national public health policy strategies are remarkably consistent, reflecting each nation's history, social and political institutions, and cultural preferences. For reasons more to do with societal and ideological than with state characteristics, however, the specific policies adopted and whether or how they are implemented vary considerably with the policy issue at hand. Policy strategies premised on a highly centralized state with a monopoly on policy initiative and implementation

have worked well in some public health arenas, less well in others. Nor is decentralization synonymous with absent or ineffective public health policies. As Vogel has observed, “instead of seeking to evaluate the relative ‘strengths’ or ‘weaknesses’ of particular states, we need to specify those policy areas in which government seems to be capable of asserting its prerogatives vis-à-vis interest groups and those areas in which it is dominated by them” (1986, 268; see also Baldwin 2005b).

Collective Action

Among the most distinctive and enduring features of American society is the perennial mobilization of civil society on behalf of ideologically defined social and political interests and beliefs (for example, Cohen-Tanugi 1987; Clemens 1997). Both today and in the past, this capacity for mobilization is nowhere more evident than in the field of public health. For example, the success of tobacco control policies in the United States is due in large part to the early initiatives of the American Cancer Society in the 1950s and 1960s and of grassroots nonsmokers’ rights groups in the 1970s (Nathanson 1999). By contrast, the society’s counterparts in Britain and France long remained aloof from the tobacco wars, grassroots groups developed later and their impact has been considerably less. (Although Canadians mobilized against tobacco somewhat later than the United States, the pattern of mobilization there was more akin to that of the United States than of Europe.) Each country’s mobilization pattern, though distinctive, is also quite constant across different public health issues.

Collective action on behalf of this or that public health policy appears in many guises, from grassroots social movements to formal organizations. In conceptualizing this variation, I draw primarily on the work of social movement scholars. Among these scholars there is substantial consensus on the categories of variables relevant to the analysis of social movements: political opportunities, mobilizing structures, command of resources, and the construction of supporting ideologies. Let me define briefly each of these constructs. *Political opportunities* are openings exogenous to movement actors themselves that encourage engagement in collective action. “There are two components to such opportunities. One component is openness *within* government to action on a particular set of issues. . . . The second is the prospect for political mobilization *outside* government” (Meyer and Staggenborg 1996, 1633, emphasis added). Further, as Meyer and Staggenborg point out, “political opportunity is not just a fixed external environment that insurgents confront, but also something activists can alter” (1634). The AIDS–drugs nexus, for example, was greeted in some quarters as an opportunity to mobilize against repressive narcotic drugs policies. *Mobilizing structures* are the formal and informal social networks through which individuals with common grievances are brought together.

A classic example of mobilizing structures was turn-of-the-nineteenth century women's clubs in the United States that served as incubators for many forms of collective action, including against infant mortality (Skocpol 1992; Clemens 1997). *Resources* critical for social movement emergence and effectiveness include tangible assets—financing, space, mailing lists—as well as intangible assets such as organizational experience, social and political contacts, and, in the case of health-related social movements, medical expertise (Nathanson 1999). Finally, a major task of social movement entrepreneurs is the *construction of supporting ideologies* or shared meanings that will inspire people to collective action (Tarrow 1998; Benford and Snow 2000). Smoking, for example, was redefined from a pleasurable habit to an assault on the lungs of innocent bystanders.

As Quadagno has recently observed, mobilization of the powerful—“stakeholder mobilization,” in her terminology—“involves the same processes that social movement theorists usually associate with the mobilization of politically powerless groups” (2004, 28).

To be effective in the political arena, stakeholders share with the politically powerless a need for leadership, an administrative structure, incentives, some mechanisms for garnering resources and marshaling support, a setting . . . where grassroots activity can be organized. . . . Even though dominant groups may have privileged and systematic access to politics and to elected representatives, they require these same resources to exert political influence. (28–29)

Quadagno's perspective is consistent with my own observations of the policy-making process. The categories developed by social movement scholars served as guideposts to my collection and analysis of data on the role of nongovernmental actors—however powerful or powerless—in advancing or protesting public health policies. The specific form of nongovernmental action—ranging from highly to not at all institutionalized—is also a variable to be explained. Among the striking facts about collective action are the degree to which it varies across countries and the degree to which its forms change and evolve over time.

Ideology: Constructing Risk

Dangers to life and health abound. Whether these dangers will elicit “community action to avoid disease” depends on relevant actors' perception of a credible and avoidable (or at least controllable) threat. Judgments of what dangers should be most feared, how to explain them, what to do about them, and even whether they are in fact public health problems are the outcome of social processes. In my approach to the analysis of risk construction, I draw on three theoretical traditions: that of symbolic interactionists who have written about the construction of public problems

(Blumer 1971; Gusfield 1981; Conrad and Schneider 1980); that of the social movement scholars' elaboration of framing processes (Snow et al. 1986; McAdam 1994; Tarrow 1998); and that of Mary Douglas and her colleagues and students, who have studied the impact of political cultures on constructions of risks to the environment (Douglas and Wildavsky 1982; Douglas 1992; Thompson 1983; Wynne 1987).

The first element essential to the construction of a credible risk is the existence of groups or individuals with the authority to define and describe the danger that threatens. Authority in public health is generally presumed to rest with medical and scientific experts. The credibility of medicine and science is, however, highly variable across cultures and political regimes. For example, scientific data on the dangers of cigarette smoking and the health risks of injection drug use as compared with the risks of HIV infection are equally available in all four countries. Neither the French relaxed attitude toward cigarette smoking nor U.S. public officials' rejection of needle-exchange programs to prevent HIV transmission among drug users were due to uneven access to scientific knowledge. They are due to differences in how—and by whom—these issues are initially framed, to the extent of their politicization, and to differences in the cultural authority of experts in addressing public health policy issues.

The second element is the assertion of a causal chain to account for the danger. At the rhetorical extreme, risks are portrayed as hidden, involuntary, and irreversible—as, for example, the risks from fluoridation of public water supplies were portrayed by its opponents when fluoridation was first introduced in the United States (Crain, Katz, and Rosenthal 1969).

The final element is the designation of victims. Risks may be portrayed as universal (we're all at risk) or particular (only they are at risk); victims may be described as innocent or culpable. For example, a major factor in the success of the smoking–tobacco control movement in the United States was the portrayal of nonsmokers as innocent victims (Nathanson 1999).

Although the dimensions along which risks are constructed vary within a limited range, a community's selection of the specific dangers to which it attends and the relative credibility of alternative constructions of danger reflect each community's mode of organization and its valued ideals and institutions. Britain offers a telling example of continuity in both constructions of risk and risk management. Writing about British industrial policy in the nineteenth century, Dobbin observes that it "has been oriented to guarding citizens against harm" (1994, 211). British public health policies that protected the tobacco industry through voluntary agreements between industry and government and that protected injection drug users through state-funded needle-exchange programs were consistent with a policy orientation that privileges the minimization of harm over the political exploitation of risks. Inflammatory rhetoric is decried, conflict among contending parties limited, and policy consensus

achieved by gentlemanly negotiation among insiders (see Vogel 1986; Jordan and Richardson 1982). In both the tobacco and the drug arenas, and in other policy-making arenas as well, constructions of risk were less polarized than in the United States, in part because the value attached to consensus makes polarized constructions less effective as counters in the political game.

Contextual Considerations

Of the four countries whose public health policies I consider, only the United States did not by the late twentieth century have some form of universal, state-supported medical care. The different health care systems were associated with differences not only in the scope and activities of public health as an institution but also in the meanings attributed to "public health." For example, in the United States, public health is identified with the poor: "the term *public health* calls up only the picture of a local health department office located downtown filled with poor people" (Beauchamp 1988, 17). In France, by contrast, suspicion is widespread that disease prevention is advocated primarily to protect the public purse (Got 1992). More generally, each country's recognition of and response to new public health threats was conditioned by how it managed routine medical problems.

Further, each country's public health history has been shaped by its most salient social cleavages: in Britain, class; in Canada, language; in the United States, race. In nineteenth-century Britain, public health problems were "understood to be problems of the condition of the working class" (Ramsey 1994, 139); in Britain, far more than in the United States, smoking has been politicized around questions of class (Marsh and McKay 1994). Canadian writing about infant mortality is heavily weighted with concern for differences between English speakers and the historically more deprived French-speaking population. In addition, most of Canada's cigarettes are made in Quebec, so that attacks on the tobacco industry have been portrayed by its supporters as part of ongoing Anglo chauvinism. Social institutions in the United States, particularly institutions for the protection of the socially and economically vulnerable, have been largely shaped by the politics of racial inequality (Quadagno 1994). The consequences of these politics for public health policy responses to the threats of tuberculosis in the early twentieth century and more recently of HIV/AIDS have been profound (for example, McBride 1991; Anderson 1991; Fernando 1993; Cohen 1997; Nathanson 2005).

The boundary-defining role of class, language, or race is played in France by the idea of the citizen. The literal translation of citizen is citizen, but the French word has connotations that go far beyond its English meaning. Citizenship in English is a characteristic of the individual; the

same word, *citoyenneté*, in French is a statement about a set of relationships that bind one French citizen to another (Duchesne 1997). The constellation of ideas that surrounds the French conception of citizen conditions French response to public health issues in complex ways. French advocates of harm-reduction policies for injection drug users, for example, couch these policies as enabling users to recapture their *citoyenneté*, that is, as enabling lost sheep to return to the fold. This imagery is absent from the rhetoric of tobacco-control advocates: cigarette smoking in no way compromises *citoyenneté*. Response to the threats of disease and death, as Rosenberg observes, “lay bare every aspect of the culture in which it occurs” (Rosenberg 1988, 30).

Sources and Methods

The case materials for this project fall into two categories: secondary sources (historical and contemporary research monographs and articles focused on the public health problems at issue as they have been addressed in each of the four countries); and primary sources, including interviews with policy actors, documents (policy, legislative, advocacy, legal) generated in the course of public health action, records of parliamentary-congressional debate on the issues in question, newspaper and other media reports, and electronic listservs for movement participants. Primary source materials are limited to the two contemporary issues; its collection was accomplished in several field trips to each of the three countries outside the United States in addition to field research in the United States.

Secondary Sources

Literature on each of the public health issues I selected was substantial. This depth was of most importance for my narratives of infant mortality and tuberculosis, because primary research on the late nineteenth- and early twentieth-century histories of these issues in each country was well beyond the scope of this project. By limiting the period of primary focus to approximately 1870 to 1915, I was able to include within my purview much if not all of the pertinent work by historians, contributing not only to my command of events in some detail, but also to my ability to cross-check the accounts of different scholars.

Reliance on secondary sources necessarily raises questions about the reliability and validity of both observation and interpretation. This problem is mitigated to some extent when different accounts and interpretations of the same events agree, though even then it is essential to be aware of the selectivity of historical records. For example, nineteenth-century accounts of tuberculosis undoubtedly overrepresent the experience of “interesting” middle-class and literate individuals, and twentieth-century accounts may overrepresent the poor who came to the attention of public

clinics, hospitals, and sanatoria. The reliability-validity problem is most serious, however, when accounts disagree, as do scholars' portrayals of the history of tuberculosis at the turn of the last century in France. I am quite sensitive to these disagreements. In addition to acknowledging their existence, I used other strategies to confront them. First, reviews of the work in question by other historians was sometimes helpful in putting disagreements in perspective or suggesting where the weight of evidence lay. Second, I carefully considered the implications of alternative accounts for the story I was telling and for its interpretation: some disagreements were more consequential than others. Although it is important to be constantly aware of the eyes through which historians' accounts are filtered, I believe that these accounts can be valuable sources for the sociologist.

Primary Sources

The sources on which I rely most heavily for my contemporary policy narratives are interviews with participants and observers in each country. I identified key actors initially through contacts at the Centers for Disease Control and Prevention (CDC) in Atlanta, at the Johns Hopkins School of Hygiene and Public Health, at the London School of Hygiene and Tropical Medicine, at Cambridge University, at the Université Pierre Mendès-France in Grenoble, at the University of Toronto, and at McGill University in Montreal. These actors included scholars, health professionals, advocates, and civil servants. I asked each of this first group of informants to identify others with whom I should speak. Consensus was remarkable across the two issues and across countries as to who the key players were, and I was able to interview almost all of these individuals. I completed sixty formal interviews more or less evenly spread across the eight contemporary cases and many more that were informal (for example, I spent two weeks as a participant-observer in the offices of the French Comité nationale contre le tabagisme at Versailles). For the formal interviews, I followed standard sociological practice for open-ended interviews, ensuring that I covered a pre-set list of topics, but with flexibility as to order and with ample allowance for respondents' digression. Almost all interviews in France were conducted in French. The majority of interviews were tape-recorded and professionally transcribed. Where recording was not possible, I made extensive notes and typed up the interview within twenty-four hours.

The purpose of these interviews was to reconstruct, for each country, a detailed account of when, how, by whom, and why a specific public health problem (such as smoking and HIV/AIDS in injection drug users) was or was not identified and was or was not addressed, and, if it was addressed, what form this action took and what accounted for the form

that was chosen. Respondents occupied a range of different positions with respect to the events on which they were reporting. From the perspective of my ability to cross-check different accounts this was a major advantage (and, indeed, their accounts agreed substantially). However, it is as important to keep in mind the particular social location from which each of these respondents reports as it is to be aware of historians' filtered accounts.

Interviews were the most important, but only one, and not the most voluminous, of my primary sources. I made extensive use of legislative debates on the issues in question; these are particularly useful in highlighting how issues are framed for public consumption as well as the sources and motives of opposition to public health policy initiatives. Contemporary newspaper and magazine reports and editorial opinions were useful for the same purpose, as well as to keep track of events as they unfolded. Advocacy organizations generate newsletters and other materials; governments generate policy reports; cases brought to court generate legal opinions; participants themselves wrote their own accounts of "what happened." I approached these sources with the same analytic questions and with the same awareness of their potential biases as I brought to the interview data.

Narratives as Data

My data are presented in a series of narratives (or dramas), recounting the time, place, and sequence in which specific public health events unfolded. In adopting this mode of presentation I was guided by a proposition basic to the case-comparative method: "that the time and place in which a structure or process appears make a difference to its character [and] that the sequence in which similar events occur has a substantial impact on their outcome" (Tilly 1984, 79). The narratives are more than stories, however. They have a common structure dictated by the need to ensure that material relevant to each of my three conceptual building blocks—states, collective action, and constructions of risk—was adequately covered. In general—I do not slavishly adhere to an identical outline in each of the sixteen cases—I begin with a more or less chronological account of how a problem emerged and what was done about it. I then describe the cast of characters—who the actors were, how they fit into the larger social and political scene, what accounts they gave of their own and others' actions. The last section of each narrative focuses on attributions of meaning: how a given problem was defined, who was seen as responsible for causing the problem, and who were perceived as its victims. Again, I did not consider this structure a straitjacket. I did not always follow the same order, and some narratives contain more interpretive material or cross-national or within country comparisons than others. Overall, however, I have tried to make the narratives sufficiently complete and sufficiently factual so that

readers can arrive at their own interpretations of the data, not necessarily the same as mine.

Finally, the narratives are ordered by public health problem rather than by country primarily to facilitate brief introductions to each problem's history and epidemiology. Should the reader prefer, the narratives may be read by country without doing substantial violence to the text. Because one goal of this work was to highlight other countries' differences from—and similarities to—the United States, each set of narratives begins with the American case, followed by France because it tended to offer the sharpest contrasts with the United States.

Plan of the Book

This is a book about history written by a sociologist. The plan of the book reflects the sociologist's impulse to separate data from interpretation. The book is divided into three parts. The first, this chapter and the next, is intended as introduction and orientation. The next chapter sets the stage, both historically and analytically, for the material that follows. In it, I portray the nineteenth-century settings in which public health as a self-conscious activity was born. Parts II and III of the book, chapters 3 to 6, present my data in the form of narratives. The stories of tuberculosis and infant mortality are told in chapters 3 and 4 and those of smoking and HIV/AIDS in injection drug users in chapters 5 and 6. In part IV, I analyze and interpret the narrative materials. The order of presentation is dictated by the conceptual framework introduced. Chapter 7 examines the roles of the state and civil society in bringing about, or blocking, public health action. It addresses the central question of why these four countries, similar in so many respects, differed in their recognition of and response to the same public health problems. Chapter 8 focuses more narrowly on cross-national variation in forms of collective action—the relative importance of “experts and zealots”—and on interaction effects (in the statistical sense) between actors, countries, and strategies. In chapter 9, I consider how differences in countries' political cultures and in qualities specific to the disease or condition (what was its history, whose interests did it affect, who were its victims) influenced each problem's construction and framing. In the final chapter I summarize and reflect on what I have learned.