Enlarging the Framework for Political Demography

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In order to understand the role of human initiative in mortality reduction, four elements ought to be considered: the biological environment, ethnomedicine, biomedicine, and politics. The biological environment includes not only humans and microscopic pathogens, whose coevolution determines which micro-organisms produce sickness and death (Wills 1996), but also the materials necessary to sustain human life: air, water, and nutrients. Ethnomedicine subsumes the study of human illness and the development of practices to prevent and cure; these practices are based on close observation but are empirical rather than imbedded in a coherent set of academic disciplines (Green 1999). Biomedicine, by contrast, consists of the integration of microbiological, chemical, and physical sciences, whose corpus is cumulative, replicable, and subject to refutation.

The relationship between politics and health is the most refractory to define of all of the elements in human health. It is vital in that it encompasses the establishment of rules intended to enhance the actions of government and non-governmental organizations in the preservation of health and governs the appropriation of funds to promote longer life. At the same time,

it contains a disreputable element: it is subject to the will of the powerful, it can be abused by the corrupt, and is ultimately the product of negotiations among parties whose interests are often far from those of the general public (Fox 1999). What is more, the configuration of circumstances in which politics affects health differs over time and from country to country.

It is therefore not possible to arrive at what Clifford Geertz (Flyvbjerg 2001) calls "general, abstract, situationally unconditioned theory ..., precise predictability, ... and `objectivist' method," goals which characterize mainstream demography. Nonetheless in the twenty first century political factors play a role in determining the basic components of demography: fertility and mortality *reduction* and *control over* migration. Indeed, structuralist arguments based on the most precise social and economic indicators can not totally explain the interaction of politics and demography in the past: the successes of the family planning movement from the 1960s onward; the role of local corruption in hampering public health efforts by international agencies; the way in which certain would-be migrants have acquired greater freedom of movement than others.

Demographers, of course, have tried to use natural science methods to explain the role of politics in demography. The 1974 World Population Conference called for monitoring laws that have a direct or indirect impact on the rate of population growth. Indeed, since then the United Nations Population Fund in conjunction with Harvard Law School has produced the *Annual Review*

of Population Law, whose articles since 1984 have been supplemented by a data base which now contains the full text of important documents. Restricting the definition of political demography to laws currently on the books, however, narrows the inquiry to the results of the legislative process, without reference to the way laws are passed, interpreted and enforced.

The first step is to recognize that different organizations often have different ways of legislating. This calls for local expertise not only in demography but in law-making for each country, international organization, and NGO. Insiders are far more likely than outsiders to know the informal ways in which legal procedures are drafted, interpreted, and implemented. They are also more likely than foreigners to detect leaks by which appropriated funds are diverted to inappropriate recipients. Given the political risks, it may be necessary to enlist retirees who have nothing to lose from exposing less than optimal practices. The same caveat extends to employees of International Organizations and NGOs: those still actively at work may have to continue dealing with dishonest civil servants or local government officials. Those who have already retired, however, could relate their experiences for the edification of their successors.

Local conditions apply to more than legal practices. Some countries are more salubrious than others. Regions within countries may also differ because of climate or access to health resources. Some territories will have benefited from long term investments in health infrastructure. Tropical areas frequently

harbor a broader range of human pathogens than temperate areas. Thus the expectations which physicians have of the health care providers may be higher in industrialized "northern" countries than in the less wealthy "south". Conditions deemed "avoidable death" in the United States and Western Europe (Rutstein 1976;Holland 1988;Simonato 1998;Treurniet 1999), may be accepted as unavoidable elsewhere (De Brouwere 1998).

Government policies relating to health have expanded preventive and curative procedures have become increasingly effective. For western Europe, the earliest effective initiatives go back to the 14th century, when various governments attempted to close their borders to plague infection (Biraben 1975; Moseng 1996). After Jenner's discovery of vaccination against smallpox, many governments eagerly assumed responsibility for the production and regional distribution of the vaccinia serum (Sköld 1996). Less effectively, European governments attempted to halt the spread of cholera during the deadly epidemics of the 1830s and 1850s (Baldwin 1999; Bourdelais 1987). Beginning in the late 19th century, led by the Germans, governments began to offer health insurance, first for workers and ultimately to their families. National governments thus differed as to when they provided health care and what services they offered.

They also differed as to the levels of government which provided services. In early modern times, many health initiatives came from municipal authorities. Urban death rates tended to be higher than rural ones, so local officials had a vested interest

in preventing epidemics, obtaining pure water, and caring for the indigent. Indeed, in many places, poor relief came to include food distribution, free vaccination, and some medical treatment.

During the nineteenth century, central and provincial governments began to act in areas which had previously been left by default to local governments. Thus, the British government first permitted and then required municipalities to appoint Medical Officers of Health to supervise public health activities. German states followed by the Kaiserreich began to legislate regarding such matters as vaccination and water purification. This expanded the scope of central government activities beyond more restricted services such as the production of vaccines and the care of military personnel (Hennock 2000; Vogele 1993).

In the United States, the federal government was reluctant to act in matters constitutionally reserved to the states. Indeed, in the 1870s, southern states stoutly resisted federal efforts to legislate measures relating to yellow fever (Humphries 1999), and in the 1920s, certain northern states refused to accept federal appropriations for the care of indigent mothers and children (Rosenkrantz 1972). Nonetheless, beginning with the Social Security Act of 1935, the federal government began sending money through the states to the municipalities (Donoghue 1979;Trattner 1999). Indeed, by the 1960s federal grants subsidized health care activities by the states, municipalities, and the counties--an intermediate level of government which had not previously played much of a role (Fox 1993).

The complexity of the relationship between central and subordinate governments suggests that work must begin on individual countries. In France, for example, one will have to disentangle the relationship between the Ministère de l'Intérieur and the mairies, the importance at the end of the nineteenth century of the départements in child welfare (Rollet 1990), and the current role of the régions. In Norway, to take another example, researchers will have to examine the development of a state-funded by highly decentralized health care system which brings together five health regions, 19 counties, and 436 municipalities (Bolstad 1995). Only after the systems have been compared can researchers arrive at some practical generalizations about the changing relationships between central and subordinate governments.

Beyond governments, we also need to know more about policy-making and implementation within international organizations and NGOs. As far as the former are concerned, we need more studies like *The United Nations and The Population Question* (Symonds and Carder 1973), which discusses the effects of Vatican II on international population policy. On the problems faced by both national governments and donors, we need more frank discussions like those of van Lerberghe and Pangu (1988: 335-367). In sum, we need to know the procedures by which international organizations and NGOs arrive at policies, how they enforce them, how they obtain funds, and how they govern their disbursal. If these procedures remained shrouded in a cloak of legalism, demographers

will never be able to understand the mechanisms by which health care policies for the poorer countries of the world are arrived at and implemented.

Indeed, comparable political questions also apply to the past. One needs to begin with government criteria for providing health services. Why, for example, were the French so much more willing to vaccinate Africans against smallpox and yellow fever than the British? (Fetter 1993). Who determined which services would be provided by Christian missions? Why were colonial governments so determined to extirpate African healers, when services were not available from other sources? How tolerant were the colonial authorities of the adulteration of anti-malarials in British India? (Muraleedharan 1998)

Beyond policy, one cannot escape financial considerations; one cannot provide preventive and curative services and scientific research without money. But how are the money appropriated? Who actually makes the decision of how much to spend, be it at the municipal, provincial, or national level? Who decides how much money should go to international organizations and NGOs and how it should be allocated among worthy causes? The expertise acquired by demographers at obtaining grants from governments and charities must be tapped, if we are to understand why some programs are better funded than others.

In conclusion, political processes affect governmental decisions to provide health care, the amount of money to spend on it, and the conditions under which health care is delivered.

Structuralist explanations which assume that systemic forces determine the nature of health care lack the means to anticipate the affect of politics on it. It is therefore esssential that strictly quantitative analyses of the determinants of health care by supplemented by consideration of the qualitative and indeed aleatory role of politics.

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