

The role of chronic pain and suffering in contemporary society

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Mette Bech Risør (ansv.), Forsningsklinikken for Funktionelle Lidelser, Århus Sygehus
Torsten Risør, Forskningsenheden for Almen Praksis, Aarhus Universitet
Gitte Wind, VIA University College, Århus
Lotte Meinert, Institut for Antropologi og Etnografi, Aarhus Universitet
Peter Vedsted, Forskningsenheden for Almen Praksis, Aarhus Universitet
Ann Dorrit Guassora, Forskningsenheden for Almen Praksis, Københavns Universitet
Susanne Reventlow, Forskningsenheden for Almen Praksis, Københavns Universitet

Gæsteredaktør:

Marie Østergaard Møller, Department of Political Science, Aarhus University
Lise Kirstine Gormsen, Danish Pain Research Center, Aarhus University Hospital

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Aims and scopes

The Journal for Research in Sickness and Society is an interdisciplinary journal which has a theoretical background in medical anthropology. The aim and purpose of the journal is to promote and develop research in the borderland between the health sciences and the humanities/the social sciences. The goal of the journal is to function as a forum in which these disciplines may meet and inspire each other – epistemologically, methodologically and theoretically. The journal conveys the debate and theoretical development which takes place in the growing collaboration and research initiatives emerging from this borderland. The journal addresses all with an interest in research in sickness and society and especially health professionals working with education and/or research in interdisciplinary institutions.

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The circular structure of policy failure and learning. Danish and American public health policy 1975-2005

Lars Thorup Larsen

Department of Political Science, Aarhus University
lars@ps.au.dk

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The literature on policy learning has focused our attention on how governments 'puzzle' over society's great problems and foster solutions based on the experience of previous policy as well as new knowledge and ideas. While policy learning is often seen as a linear process, this article aims to show how the learning process can also be circular in the sense that the previous policy from which a given new policy departs is constructed over and over again, which should not be confused with actual past policy. The argument is backed by a comparative policy analysis of lifestyle-focused public health policy in Denmark and the United States over the past three decades. While downplaying their belief in traditional medical treatment technology, most Western nations shifted their health policy objectives in the mid-1970s in order to get into what one report termed 'the business of modifying behaviour', i.e. to counter lifestyle diseases by getting citizens to exercise more, but eat, drink, and smoke less. Based on a study of three decades of Danish and American public health programs, the article shows how two very different health care systems experienced

a similar pattern of policy failure. While both systems continually experience that citizens fail to live by what they know is healthy, public health policies always seem to be able to generate strong optimism for each new policy program, because the values responsible for policy failure are associated with the medical treatment paradigm that the policies depart from, but never with prevention itself.

Introduction

During the 1970s, most Western countries began to adopt major public health plans to counter the rise of lifestyle diseases and the costs associated with them. While downplaying their belief in the prospects of medical treatment technology, governments now looked upon the potential advantages of preventive public health policy with unbridled optimism. It has now become a persistent policy goal for most governments to promote healthy lifestyles among their citizens using a comprehensive array of policy instruments targeting issues like smoking, drinking, diet, and physical exercise.

If we try to understand this policy development, it is difficult to avoid the benefit of hindsight and argue that such policies were simply the only natural response to new medical facts as well as to a tight situation for financing welfare in most countries. Some of these seemingly obvious reasons are older, however. Not only did knowledge on the risk factors of human lifestyle exist prior to this decade, but even more important, several of the governing principles behind this preventive turn had been developed almost thirty years earlier when the World Health Organization was established. The organization was built around a positive and inclusive concept of health, holding in itself the promise of a shift from medical treatment of diseases to a set of proactive efforts to promote the well-being of all human beings. WHO's constitution boldly declares that "... [h]ealth is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 1948: p.2). By a swift stroke, this definition also makes the ambitions of public health policy all-inclusive, especially since WHO's concept of health has traveled extensively through public health documents across the globe.

In itself, this broad idea does not clarify why comprehensive public health policies emerged in the 1970s, nor does it help us to understand the further development of the area. It is essential to recognize that the development in this area is as much a story about power as it is about health, and it is the ambition of this article to highlight and sort out these two threads. Besides trying to come to terms with

new health problems and a new conception of health centered on lifestyle, public health policies are equally characterized by a continuous development of power relations in order to make the population's health manageable and intelligible as a political problem. The two threads will not be presented separately here, however, because they are intimately connected with all three stages of policy development covered below.

The question is what type of policy theory can help us understand this shift towards lifestyle-centered public health policy – or ‘the new public health’ as it is also called (Petersen & Lupton, 1996) – and how problems and solutions were associated in the process. One possible candidate would be some variation of what is often called policy (or social) learning. The policy shift from treatment to prevention and health promotion definitely involves some aspect of what Hecló's landmark study called a ‘collective puzzlement on society's behalf’ (Hecló, 1974: p.305), first because the period saw a considerable collective diffusion of health policy ideas, and second because governments puzzled extensively over how to regulate individual lifestyles. Finally, in a very crude sense this was in fact a process of puzzlement on the entire society's behalf, since the end objective was to extend the life span of the population.

Different approaches to policy learning

In his review of various positions on policy learning, Richard Freeman distinguishes between the mechanistic or positivistic conceptions of the policy learning process on one side and the organic or constructivist conceptions on the other (Freeman, 2006: p.379). The main point is not to oppose two groups of policy theorists, but to focus on the key variables on which they sometimes disagree. At least two theoretical differences are important here: the *first* concerns what is the subject of the policy learning process, or simply what is learned. Is it a mechanical transfer of a ‘thing’ or piece of information where one group of actors learns how to solve a clearly defined, preexisting problem? Or should policy learning rather be understood as a constructivistic process where both problem and solution are co-created in some kind of emergent assemblage?

The *second* distinguishing characteristic of various positions on policy learning is how they conceive of the process itself. In the words of Hecló, the most important factor in policy learning is “the impact of previous policy itself” (Hecló, 1974: p.315). This is in line with several other positions in public policy literature, for example concepts like path-dependence and policy legacies (Pierson & Skocpol,

2002: p.699; Steinmo, Thelen & Longstreth., 1992; Hall, 1993: p.277), but the specific merit of policy learning approaches is that they devote more attention to how previous policy is made relevant in new policy developments. In the mechanical conception of policy learning this process is normally understood in terms of linear causality, i.e. as an independent variable. The constructivist approach to policy learning replaces the linear view with a more circular understanding. Rather than previous policy exerting independent causal pressure, the relationship between policy past, present and future is continuously reiterated and reinterpreted in an ongoing process (cf. Freeman, 2006: p.373). In the case of circular policy learning, one cannot be certain that anything substantial is actually learned, only that the new policy presents itself as being inscribed within a process of collective puzzlement.

If we were to imagine how these different aspects of policy learning might influence our understanding of the shift from treatment to prevention, it is perhaps easier to discuss a specific approach. A very influential example is Peter Hall's (1993) theory of policy paradigms inspired by Kuhn's history of science, and although it is in no way extreme on these points, Hall's position definitely leans towards the mechanistic conception of policy learning. He defines the latter – or rather 'social learning' as he prefers to call it in accordance with Hecló – as "... a deliberate attempt to adjust the goals or techniques of policy in response to past experience and new information. Learning is indicated when policy changes as the result of such a process" (Hall, 1993: p.278). Furthermore, Hall differentiates the changes resulting from policy learning into three orders of which only the last constitutes a true change of policy paradigm (Hall, 1993: p.279). Applied to the present case, the shift from treatment to prevention in the 1970s would be interpreted as a third order (or policy paradigm) change, because it came with an entire new set of policy goals as well as changes at the other two levels, i.e. policy instruments and settings. The later development of public health policy in the 1980s and 1990s, on the other hand, would only constitute second order development of health-promoting techniques or first order adjustments in the application of these techniques. Although it is debatable how easily Kuhn's history of science can be translated into a pattern of policy development (see Larsen, 2010), it probably makes sense in most cases to differentiate between smaller and larger policy changes in this way.

This article uses public health policy to demonstrate a different theoretical point, which is less concerned with differences in the scope of policy change. Rather, the main objective is to show that understanding policy change and learning

in this linear fashion is highly problematic as it tends to undermine some of the analytical benefits of a learning or idea-centered perspective on public policy. In contrast to the conception where policy learning is merely seen as a linear succession of different levels of knowledge, this article advocates a circular conception to illustrate how each period reconstructs its own past, present, and future, even if in hindsight it may look like a repetition of the same mistakes and self-delusions (cf. Freeman, 2006: p.373).

Campaigns that focus on prevention and lifestyle never really replace the treatment paradigm in health policy, but they continue to reinvent themselves as a departure from a failing treatment paradigm and thus to supersede past failures by continuously reinterpreting the past. In other words, policy learning does not necessarily imply improvement or a higher state of knowledge as we move forward in time, only that the policy outcome at any given time is processed through the filter of policy ideas telling policy makers where we come from and where we are going policy-wise. As the empirical study attempts to show, preventive public health policy is a constant reaction against treatment-based health policy and all the values and ideas it represents. Before we turn to the study itself, it is necessary to clarify some of the theoretical and epistemological underpinnings of the article, first in the form of a Foucauldian perspective on knowledge, second a few indications on the applied research design.

Stealing ideas from Foucault

Michel Foucault's work has been pervasive in many branches of the social sciences including studies of politics, but mostly in the relatively diffuse sense of referring to him as the grandfather of social constructivism, discourse analysis and the like. Instead of departing from these broad and diffuse categories, the aim here is to take up two more specific ideas from Foucault's later work and briefly state their relevance for this study of public health policy.

The first one is the concept of *genealogy*, which forms the epistemological strategy behind Foucault's renowned studies of punishment, sexuality, and governmentality (Foucault, 1975; 1976; 1984a; 1984b; 2004a). Although it often involves lengthy, historical studies, the core idea of genealogy is really about opposing the idealistic narratives that are already embedded in our present conceptions of truth, justice, or health. Genealogy is always about writing a sort of counter-history that aims to show how the origin of contemporary ideals is more ambivalent or heterogeneous than presumed in these narratives. On this point, Foucault was

inspired by the German philosopher Nietzsche, who used genealogy to argue that the origin of morality was not the 'Wunderursprung' claimed by moral philosophers, but basically an act of power distinguishing the good people from the bad (Nietzsche, 1984: p.13; 1994). In a broader sense, this type of critique goes against all narratives in which the origin is presented as being simple, clean, and unequivocal (Foucault, 2001: p.1007). In effect, genealogy is a forceful tool in the critique of linear policy narratives as outlined above. By comparing the constructed origins of public health policy across time and different countries, it should be possible to reconstruct a different and more heterogeneous story about the policy development from treatment to prevention.

The second concept to be introduced here is the category of *biopolitics*, which Foucault introduced in the late 1970s to describe the way power relations have become pervasive in modern society with the ultimate target to optimize, care for, and better the life of the population (Foucault, 1976: p.175-211; 2004b; Larsen, 2007). The shift from territorially based political power to biopolitics has tremendous implications for our general understanding of power, but the point here is more subtle and only concerns an internal tension in the exercise of biopolitical power. As Foucault states in his seminal work on biopolitics, *la Volonté de savoir*, modern man is a creature whose entire life has become the object of political calculation and whose existence is therefore regulated by series of relations between power and knowledge (Foucault, 1976: p.188). What this means, however, is not that governments are actually able to control all this, only that no details of human life are too tiny to *potentially* become the target of biopolitical regulation. In other words, there is an embedded tension between the all-embracing pervasiveness of biopolitics on one side and a continuous struggle to make power relations work better on the other. As the empirical study will demonstrate, this duality is very presently felt in the area of public health policy where the bold ambitions often stand in contrast to experiences of powerlessness and policy failure.

Research design and objective

The cross-country comparison of Danish and American public health policy involves a so-called 'most different' approach with two very different cases displaying similar characteristics on key points. One of the basic tenets of my argument is that the development of the new public health cannot simply be understood as a natural reaction to a given set of objectively defined health problems. If this study can demonstrate that two very different countries with very different systems of

health care provision nonetheless have similar experiences with preventive public health policy, this supports the claim that health policy is not a direct consequence of the population's epidemiological profile. The life style turn in public health policy was not created by life style diseases, in other words. This study does not aim to describe the health status of Danes or Americans, but it uses the similarity of their reactions to demonstrate a theoretical point about the circularity and continuous reconstruction of policy origins.

It is fairly easy to establish points of comparison between the three major public health programs from each country, since they tend to arrive at decade-long intervals beginning in the late 1970s. The first Danish report on future priorities in the health care sector appeared in 1977 followed by dedicated public health programs in 1989 and 1999 (with minor revisions in 2002). This is remarkably similar to the chronology of major US public health programs from the initial *Healthy People* (published in 1979) to *Healthy People 2000* (from 1990) and finally *Healthy People 2010* (from 2000).¹

The study thus comprises all the major public health programs in Denmark and the United States from 1975 to this date, and only material from central government agencies or ministerial departments is included. Obviously, it is possible to think of many other types of data material as alternatives to approach the topic, e.g. interviews or participant observation, but effectively they would lead to the production of a different type of knowledge. Since the aim here is not to analyze individual or collective action as such, but rather to reconstruct the internal reflection of governmental rationality, sticking to the text-based data set seems more appropriate. In exchange for detailed subjective experiences, genealogies generally use programmatic texts as their main source of data, because such texts reflect upon the behavior and being of citizens according to some principle of rationalization, calculation, obedience, or self-development. By analyzing these texts, one can thus hope to document a "... particular 'stratum' of knowing and acting" (Rose, 1999: p.19).

Another reason for focusing only on the written policy programs is to distinguish the paper's analysis of policy learning and policy failure from the question of implementation, which is not the issue here. Contrary to implementation research, my aim is to demonstrate how much reflection on success and failure is already embedded in the constructive rationality of a given policy long before it is ever put into practice. Not to disregard the obstacles of implementation, but because the internal tensions in a set of policy ideas can easily be overlooked in

such an analysis because ideas are assumed to have been clear and unequivocal at their inception.

Governments need to get into the business of modifying behavior (1975-1988)²

By the mid- to late 1970s, public health programs in both Denmark and America took as their point of departure the assumption that because of lifestyle diseases, it was no longer possible to improve the population's health status significantly through disease treatment.

The first Danish public health plan from 1977 was drafted with the overall priorities of the health care sector in mind, but although the theme of prevention was absent from the original parliamentary mandate (DK1977: p.11), its main focus is on how the Danish health care sector can take a major leap towards a preventive approach. The shift presents itself primarily as a change of means, while the biopolitical commitment of health policy is intact:

The objective of the previous development of the health care sector has been to better the health condition of the population as much as possible and to provide the best possible means of aid to the individual in case of illness, for example by means of advanced medical or technical assistance. The proposals of this commission have no intention to change that, but merely suggest an adjustment of the means to continuously realize this natural objective for the efforts of the health care sector (DK1977: p.52).

The proposed shift towards prevention was justified on two grounds: previous preventive efforts had been modest, and previous experience seemed to suggest that no major gains in the population's health status could be achieved through extended resources for treatment technology (DK1977: p.51). The growing disbelief in treatment is expressed without any overt documentation, and the choice of alternatives is likewise obscure in terms of sources. The commission 'assumes' that the largest health gains can be achieved by means of prevention, but in spite of an initial wish to select preventive efforts based on what is proven efficient, the efficiency principle is later renounced on grounds related to the very nature of preventive action (DK1977: p.26). So, not only was prevention seen as being good in itself, it was also justified in terms of efficiency, although the latter was strangely seen as difficult to document.

The commission report recognized two epistemological problems in preventive public health policy, both related to the perceptions of problems and solutions. First, the program spoke of a 'paradox of prevention' as follows: "only when the possibilities of treatment seem to have dried out, does a growing interest in prevention spring forward" (DK1977: p.264). It was the temporal dynamic that was supposedly paradoxical, because the priority for early intervention tended to emerge after the possibility of repair has vanished. Only in retrospect did a new common sense argument present itself saying that: "at all times it has been agreed upon that it is better to prevent than to cure" (DK1977: p.272). It could be questioned when is really the right time to evaluate the effectiveness of prevention versus treatment. The second epistemological problem relates to the consequences of prevention once put into action. Under the bold title 'the dilemma of prevention', the commission report recognizes that no one can ever document the efficacy of preventive action scientifically (DK1977: 265). Intervention and result are often so far apart that it is impossible to judge whether the given changes in health status were in fact due to the chosen form of prevention, not to mention that the occurrence of disease is only probabilistic. The problem may have been prevented for entirely different reasons, or perhaps the targeted problem simply did not occur as expected. Preventive action lacks this precise epistemological 'check', which is also noticed at a philosophical level in Slavoj Žižek's analysis of preemptive warfare (Žižek, 2003).

It is interesting in itself to observe how public policy programs embody their own epistemological reflection in which an interpretation of the past connects to future promises. This is clearly an example of 'collective puzzlement' in Hecló's sense of the term, but with the important footnote that the commissioned experts not only puzzled to solve a well-defined problem, because a considerable part of their job was to figure out what the puzzle was even about. It is as if the policy program constructs its own quasi-epistemology including its own time and space, criteria of success and failure, and especially procedures for how to react to the experience of failure. The prevention paradox illustrates this point perfectly: Only after having experienced the failure of treatment does the argument come forward that prevention has been preferable "at all times".

This is not a simple mistake by the authors, because practically all the health programs use this type of simple temporal narrative criticizing earlier approaches of taking an overly "passive" approach, which is now to be replaced by a more "active" stand for health. The association between the passive 'before' and the active 'now' can take different forms, for example by stressing the need to focus

on a broad concept of health as opposed to looking only at the physical side, the need to approach the 'normal' adult citizen as opposed to going after vulnerable subgroups such as children or pregnant women, or finally the need to get individuals to participate actively in their own health improvement instead of merely passing out information to passive recipients (DK1977: p.265, 277). The projected past, present and future of such arguments are not 'real' in the sense that they refer to actual historical time periods. They refer only to the constructed time and space of the policy itself.

What is striking about this commission report is that even though it appears to build political decisions on rational reflection, there is no linear and direct connection between problem and solution, i.e. between what seems successful or a failure in the process of promoting health. The best example is the experience of contemporary medical treatment technology, which has failed to extend the population's life span any further. Why is this necessarily experienced as a failure and not as the clear triumph of previous efforts at curing disease?

A similar point regards the expected gains in life span from new preventive efforts: why is the commission report so optimistic about the future promises of prevention? The report itself acknowledges both that the effectiveness of prevention is hard if not impossible to ascertain (DK1977: p.265, 272), and also that most of what is actually known about the effectiveness of health education concerns what is known *not* to work (DK1977: p.277). The point here is not just to expose the ambiguities existing in any given political program, but to observe the report's main argument about the shift from treatment to prevention. A seemingly simple shift turns out to build on more complicated premises, and in addition, the clear preference for preventive action appears to base itself on grounds not revealed in the main text. We should now look at the American program from the same time period and observe whether it displays a similar or different image of the shift from treatment to prevention.

Even before the first American public health program was launched in 1979, a number of smaller 'forward plans' and 'task force reports' were drafted. They illustrate the initial reflection that accompanied the turn towards preventive action. *The Forward Plan for Health for Fiscal Years 1976-80* emphasizes the necessity of an attitude change in the health care sector in order to focus less on treatment and more on the health behavior of individuals, but recognizes at the same instance that while prevention is of utmost importance, there is very little knowledge about its effectiveness (DHEW, 1974: p.7-8). If we move to a similar plan from two years later, the call for change is suddenly articulated much more strongly as the plan

launches an “aggressive prevention strategy” (DHEW, 1976: p.5). The latter ‘forward plan’ from 1976 embodies the same peculiar duality of failure and optimism that we saw in the early Danish report. This new forward plan fully recognizes that previous efforts have been scarce, and those that did exist were largely in vain (DHEW, 1976: p.70). Still, the aggressive prevention strategy is launched with unbridled optimism: “[A]bsent any major scientific breakthrough such as a cure for cancer, the greatest benefits are likely to accrue from improved health habits rather than from further expansion of the health care system” (DHEW, 1976: p.5). This argument was already established in the preceding year’s forward plan (this document, the *Forward Plan for Health FY 1977-81*, was regrettably unavailable for the present analysis), and it crops up again in almost identical form in *Healthy People*, the first fully-fledged American public health program issued in 1979 (US1979: p.425). We will return to the question of scientific breakthrough later on, but for now the essential point is to notice the bits and pieces from the preceding documents assuming the form of a more comprehensive policy in US1979.

The main reports, *Healthy People* from 1979 as well as the following year’s short-list of “Objectives for the Nation” (DHEW, 1980), were published by the Surgeon General in order to reach both federal health agencies and the health administration of individual states. Compared to the earlier forward plans, the *Healthy People* report resembles an actual political program in the sense that it lays out priorities, objectives and means to reach the goal of a healthier population. This being said, the program’s main intention is to build up a new policy area and therefore it is much more articulate in its formulation of goals than in devising means to reach these goals. With regard to the program’s actual control of the population’s health status, the US1979 retains the same dual experience of powerlessness and optimism that distinguished both the early Danish program and the initial American draft reports between 1974 and 1979. Compared to its Danish counterpart, though, the first American program is clearly authored by a larger number of contributors and as a result, its built-in epistemology is not centered in a few individual arguments as we found the Danish committee’s reflection on the so-called ‘paradox’ and ‘dilemma’ of prevention. The US1979 argues instead that great improvements in the population’s health status are within reach if only individuals would follow a few simple “good health habits”, and from the presentation it seems clear that the program does not imagine difficulties in getting citizens to adopt these practices.

The chapters dedicated to cancer and cardiovascular diseases appear to be pivotal in the first *Healthy People* program, because these were the two major new

groups of chronic diseases in the post-war period. Reflecting on the associations between the rise in these diseases and certain lifestyle factors, the program is very optimistic about its own abilities and reads them as a "... tantalizing indication of the potential of prevention" (US1979: p.5). The strong confidence in prevention that is typical of all these early public health programs is balanced by a declining faith in the progress of science. In that sense, the optimistic view on prevention is to some extent relative, i.e. prevention could seem as a last resort in the absence of new treatment technology. The US1979 consequently sticks to the principle of the forward plans, which states that in the absence of a cure for cancer, the greatest increases in the health status of Americans are expected to stem from improved health habits (US1979: p.425). This argument usually goes hand in hand with a new interpretation of past advances in public health.

On this point, US1979 claims to build on population studies by the renowned British medical historian Thomas McKeown, whose main work was published throughout the 1970s (McKeown, 1979; McKeown, Brown & Record, 1972). He documents that medical treatment technology was in fact not responsible for the drop in mortality rates and for the radical leap that occurred in British and Welsh life expectancy over the last 150 years, in particular in the second half of the 19th century.

Technology played a surprisingly small role in the demographic changes of industrialization, easily provable by the simple fact that the relevant drops in mortality rates set in earlier (McKeown, Brown & Record, 1972; US1979: p.164-165). The point here is not to dispute McKeown's historical analysis, which appears to be widely accepted, but rather to observe how the health program reinterprets McKeown as someone who would advocate a new lifestyle-oriented prevention strategy.

In the US, the association between McKeown's analysis and the advocacy of health promotion is probably inspired by the Canadian 'Lalonde report'. This document was drafted by Marc Lalonde, Canadian Minister of National Health and Welfare, in 1974 under the title *A New Perspective on the Health of Canadians* (Lalonde, 1974) and has inspired public health ideas on several key points. In the passage on McKeown, Lalonde argues quite simply that since health gains in the past were the result of changes in environment and behavior (for example in smaller family sizes), this must be a clear indication that governments should now pursue a public health strategy focused on life style. The natural consequence must be, he argues later in the document, that it is time for governments to "... get into the business of modifying behavior" (Lalonde, 1974: p.13, 36).

However, McKeown's analysis does not advocate public health policy of the sort envisioned in the Lalonde Report, US1979 or in any of the other programs analyzed here. Two main differences spring to mind. Firstly, the diseases to which treatment had offered little help, according to McKeown, were not life-style diseases, but infectious diseases. Secondly, the means actually responsible for the improvements in overall health status were sanitary practices, better housing and nutrition, all factors without any clear connection to the healthy life-style habits advocated by the end of the 20th century. Or, to be more exact, if any connection does exist between previous public health policies – for example the abolishment of scarcity in the West throughout the past century – it is not that we have downgraded prevention efforts in favor of medical treatment during the intervening period. The connection is rather the opposite in the sense that late 20th century life-style diseases seem to be a side effect of the exact same developments responsible for improved health status earlier in the century. In the end, the argument seems to be that the huge improvement in human living conditions over the 20th century has led to a situation with too much convenience to uphold a healthy lifestyle. Put bluntly, present day diseases are the product of previous efforts in the area of prevention in the sense that old public health policies made possible the huge leap forward in nutrition and food supply, which eventually contributed to the rise of lifestyle diseases.

What should be in focus here is not merely the correct interpretations of McKeown or of the history of industrialization. Rather, the discussion demonstrates that the experience of medical treatment failing to deliver its promises is not a 'real' experience, i.e. the product of any systematic trial-and-error process. It is a tactical platform for the launch of a new prevention strategy that makes use also of the period's critical sentiment towards medicine such as in the so-called 'anti-medicine' of which Ivan Illich's 1975 book *Limits to Medicine* is a prime example (Illich 1995). In the process, McKeown's widely accepted historical evidence takes a twist, and so does the program's interpretation of public health in the past. Again we find the tactical use of simplified dichotomies, for example when the health education of 19th century sanitation policy is characterized as a 'passive' instrument as opposed to the active ones necessary today (US1979: p.425). Considering the severe measures of Haussmann's sanitation of Paris in the 1830s – the epitome of modern sanitation – it is quite a stretch to characterize it as passive; and this while at the same time presenting today's efforts as a direct continuation of what was previously responsible for improvements in health following McKeown's argument. Besides the rhetorical advantage of seemingly moving from the pas-

sive to the active, the “active” characterization sets a new yardstick by which we should properly judge health-promoting interventions. What matters now is their ability to actively form not just social surroundings and architecture, but the habits and values of the individual.

Caught up in the claimed necessity of an aggressive public health strategy, both programs are probably weakest in their provision of actual means to reach these ends. This is also due to the simple fact that at this point, knowledge about what policy measures can make people healthier was more or less nonexistent. Contrary to making means and ends work together, the public health programs of the 1970s dedicated most of their attention to justifying future interventions, as well as to generating new knowledge. In order to project an image of the necessity of health promotion, all health programs of the time seem to discard the belief in disease treatment, but not by necessarily changing treatment practices in the health care sector and not by proposing any significant changes in their financial or organizational underpinnings. What happens instead is a retrospective reassessment of the epistemology of disease treatment. By the time disease treatment stopped working as a strategy to systematically improve the health of the population, health administrators suddenly began to question if it had ever worked. As argued above, this experience is not just the bliss of hindsight, because how can something that does not function in the first place ever stop working?

The previous discussion has shown that the emergence of new prevention policies in the 1970s was concomitant with a series of teleological narratives about the indisputable necessity of prevention. Nevertheless, the shift in health policy to include major proactive interventions into the population’s health habits does not build on any natural development, nor does it rest upon scientific or economic necessities. It was decided at some point that governments had to “get into the business of modifying behavior”, and for this reason treatment technology had to be a failure.

The nation has within its power to save many lives (1989-1998)

If we move forward a decade, we should be able to observe how each country’s policy looks back on the previous shift from treatment to prevention and whether it has been able to overcome the experience of powerlessness with respect to improving the population’s health status. Is there still an experience of policy failure and is it any different around 1990 than 10 to 15 years before?

In the former period the Danish programs were quite elaborate, but in this period the American *Healthy People 2000* (US1990) appears more general and comprehensive in its reflections on the promises of public health. A few years prior to the launch of this major program, the Institute of Medicine of the National Academy of Science gathered a number of national associations with state-of-the-art knowledge and published the milestone *The Future of Public Health* (IOM 1988). Despite the ambitious efforts of the 1970s, this publication was very critical of the previous policy as indicated here:

This study was undertaken to address a growing perception among the Institute of Medicine membership and others concerned with the health of the public that this nation has lost sight of its public health goals and has allowed the system of public health activities to fall into disarray (IOM 1988: p.19).

This was a perfect platform for the next public health plan to respond to; and although the US Assistant Secretary of Health James O. Mason stresses the continuity with *Healthy People 1979* (Mason 1990: p.23), the experience of failure allowed the *Healthy People 2000* to present itself as the right answer to resolve the situation of disarray (US1990: p.vii). The Assistant Secretary writes in the enclosed letter to his superior, Secretary Louis Sullivan:

We can no longer afford *not* to invest in prevention. From the perspective of avoiding human suffering as well as saving wasteful costs for treating diseases and injuries that could have been prevented, the 1990s should be the decade of prevention in the United States" (US1990: enclosure; emphasis in original).

The US1990 presents itself as an answer to all the criticism formerly raised against its predecessor. In contrast to US1979, which was now criticized as being "top-down, science-driven, and professionally dominated" (US1990: p.vii), the new American public health plan considered itself as having a much broader basis. If we recall the discussion of US1979 above, the quote also reveals a general point about the construction of past and future in policy programs. In this quote, is not the contrast between past and present surprisingly similar to what we saw in the former program? Consider the fact that all public health programs of the 1970s renounced the belief in treatment technology, a renunciation that was also critical of the medical establishment as well as the top-down relationship it supposedly created between doctors and patients. US1990 criticizes its predecessor for being exactly what this predecessor claimed to supersede, because "top-down, science-driven, and professionally dominated" in this context basically means a

medically dominated treatment paradigm. In this sense, the critical reflection on the previous policy is not only a question of unfulfilled promises, but also an indication that public health policy is still trying to get away from medicine. Policy learning thus runs in a circle, because every new articulation of past failures serves to justify the new program more than actually describe what happened before.

An even clearer display of US1990's hollow attack on paternalism can be found in the program's introduction. Like most other public health programs, this one begins from the experience that previous efforts have failed. Despite progress in the past decade on some variables, the main position is that "... the Nation continues to be burdened by preventable illness, injury, and disability" (US1990: p.5). In this version of policy failure, unattained goals are almost seen as a positive experience, because they serve as an open invitation for new proposals. The few health factors actually showing progress from 1978 to 1990 in the US – such as infant and child mortality – are probably more likely a result of general living standards and socioeconomic factors, and yet, the preventive lifestyle approach is still presented as the far most promising way to go:

The Nation has within its power the ability to save many lives lost prematurely and needlessly (...) the challenge of *Healthy People 2000* is to use the combined strength of scientific knowledge, professional skill, individual commitment, community support, and political will to enable people to achieve their potential to live full, active lives (US1990: p.6).

This also illustrates the complexity of the Foucauldian notion of biopolitical power, because what does it really mean for the nation to have people's lives "within its power". It seems as though any piece of epidemiological evidence that involves preventable lifestyle factors automatically warrants the conclusion that the health problem in question falls within the power of public health policy. On the one hand, this is mainly wishful thinking saying that since almost everything affects a person's health, the object of health policy must therefore be similarly broad. On the other hand and although issued by a federal governmental agency, the quote does not actually say that the government has within its power to save lives, but "the Nation" does. Besides disguising the authority of the executive, this also serves to somehow include the American people within the circle of power, which is also indicated by spelling "the Nation" with a capital N.

Definitions of the nation are abundant, but here we will only focus on the nation's status as acting subject. Several paragraphs in US1990 emphasize the national

as opposed to federal character of this program (US1990: non-paginated colophon and letter of enclosure). While a federalist political principle is somewhat exclusive, because it separates concentric domains of sovereign rule, the present idea of “the Nation” is all-inclusive and implies that no one falls outside the program’s domain of participation and responsibility. Enclosed in this nation are not just individuals, local communities and the individual states, but also an unlimited number of professional associations, interest organizations, private businesses, and so on (US1990: p.vii, 6).

Later, we will return to the framing of public health as a specifically *national* concern, but with respect to the power of public health policy, we should take notice of this inclusive definition of the program’s authorship. If all constituent parts of the nation contribute to the formation of people’s health status – which they do under the broad health concept of the WHO – then it makes sense in a very redundant way to argue that the nation has this health status within its power. What is vital to distinguish, however, is that health is not therefore under the actual control of any agency, policy, program or government. It is merely within the responsibility of the entire nation, but since nations cannot act – which is the reason why governments were invented in the first place according to the folklore of political theory – improvements in the population’s health status are very difficult to attain. Almost all contemporary health programs bear witness to this duality of omnipotence and powerlessness.

Before proceeding to the cross-country comparison, we should note another key characteristic that sets the US1990 apart from earlier efforts, namely health disparities among races and social classes. It is the first time an American public health report recognizes health disparities, but this is quickly reinterpreted to fit the persistent movement towards prevention. Disparities offer a new, “social” interpretation of why public health programs experience failure as well as optimism as we have seen in both Denmark and the US since the 1970s. This means that both the failures of previous policies and the promises of new ones are identified with specific groups of unhealthy citizens.

US1990 had three main targets: 1) to increase the span of healthy life for Americans, 2) to reduce health disparities among Americans and 3) to achieve access to preventive services for all Americans (US1990: p.43). The previous program, US1979, had already observed that life style diseases correlated differently with various subgroups of the population, but it did not translate this idea into action, probably because its actual knowledge about the social distribution of health and of possible means of intervention was extremely sparse (US1979: p.165). What it

did not know, it could not set as a chief goal of the country's public health policy. Hence, the new element in US1990's three overall targets is primarily the second point about balancing the social distribution of health, a key point also in the WHO declaration "Health for all 2000" (WHO 1979). The social dimension allows the particular public health program to pinpoint the exact nexus from which the population's health status can and ought to improve:

Although health statistics that take race and ethnicity into account are sparse, the ones that do exist leave no doubt about disparities. The greatest opportunities for improvement and the greatest threats to the future health status of the Nation reside in population groups that have historically been disadvantaged economically, educationally, and politically. These must be our first priority (US1990: p.46).

Although US1990 clearly intends to speak to the entire nation, especially in the introduction, it appears above all to be the disadvantaged groups and racial minorities, whose health status is not satisfactory. The program thus makes a social demarcation of the problem it tries to address, and in terms of documented risk factors, the selection of priority groups seems to be on solid ground (US1990: p.29-42). Yet, the data on disparities does not render the report's simultaneous sense of failure and optimism any more comprehensible. The exact same part of the American population whose health status had failed to improve in the past is now expected to take a great leap forward in the coming decade. It would be easier to make sense of this duality if it concerned different fractions of the population, some with better prospects than others, but in this case, the optimism on behalf of disadvantaged groups lacks any qualification whatsoever. Instead, health disparities serve as the basis for a general argument about responsibility in the document.

The distribution of responsibility is not exactly transparent in US1990. For one thing, the program's third goal to achieve access to preventive services for all Americans is not a preamble to coming changes in the country's system of health insurance, even though it may sound like this. In fact, US1990 discusses health insurance much less than the programs and forward plans of the late 1970s, which were more or less built on the expectation that the US was about to take a major leap under the Carter administration towards universal health coverage (DHEW, 1974: p.10; 1976; US1979: p.295). It would be fair to anticipate that a possible national health insurance would somehow affect the planned interventions in disease prevention. Judging from the documents available to this analysis, however, the shadow prospect of national health insurance seems to have very little impact on the

changing rationality of public health. This prospect surfaces in the 1970s, but then vanishes without any visible repercussions in the approach to prevention, and when the call for individual responsibility toward one's own health eventually tightens in US1990 and US2000, there is no immediate imperative in expenditure policy to account for these transitions.

If we take a closer look at the chapter on responsibility, US1990 displays a rather complex economy of 'shared responsibilities' that is not reducible only to the responsibility of individuals (US1990: p.85-88). In tune with what was indicated earlier, US1990 does not claim to build upon a divided, zero-sum type of responsibility, which would be the normal expectation in a federalist political regime. On the contrary, the document says that responsibilities are shared between individual, family, community, professionals, media and government agencies (US1990: p.85). The very idea of enumerating all these actors is not new, since already US1979 had a simple model of the individual's health within a series of concentric circles (US1979: p.6; cf. also DHEW, 1978: p.1). US1990 differs on this point, because it defines all these sorts of responsibility without even attempting to figure out where one ends and the other begins. The following quote about healthy lifestyle changes illustrates this point:

While the responsibility for change lies with each of us, it also lies with all of us, and individuals cannot be expected to act alone (US1990: p.85).

Regardless of its common-sense qualities, this point of departure is very confusing, not only for the ambiguity of each and all, but also because this section on responsibility seems to collide with the principal focus on special populations of minorities and disadvantaged groups. Running across the supposed responsibilities of 'each of us' and 'all of us', US1990 appears only to consider 'some of us' as crucial subjects of health imperatives and government intervention.

Before drawing conclusions on the major changes in public health throughout the middle period, we need to look at the Danish 1989 contribution, *Regeringens forebyggelsesprogram* (DK1989), which is far less comprehensive than its American counterpart. DK1989 continues the trend in all the other public health programs of first discussing the failure of previous policy yet still presenting surprisingly similar policies with sheer optimism. In this case, the report considers the use of hospital treatment as the most general health care mechanism to be largely ineffective:

A disproportionate relationship has emerged between the results of treatment interventions on one hand – as exceptional as they may be – and on the other hand those results and the accompanying quality of life that could have been sustained if the preventive intervention had been initiated in time and had been received by the population (...) By increasing the quality of life for coming generations of elders through a substantial intensification of preventive interventions on those who are now middle-aged, we can achieve a much larger effect on the general health status than is possible in most areas of the treatment sector (DK1989: p.8, 14).

The two quotes illustrate the innate complexity of the overall shift from treatment to prevention, especially in what concerns the claimed connection between past and future. It is not at all clear when the ‘disproportionate relationship’ is supposed to have emerged, since this was already the case in the first Danish health program 12 years prior to this. DK1989 does not make it perfectly clear whether the same disproportion is still effective in 1989 or whether a new disproportion has occurred in the meantime, despite or even because of the early program (DK1977). Again, policy learning appears to be circular, because the same arguments are repeated from the decade before. It does not mean that anything substantial is actually being learned, only that a process of collective puzzlement is set in motion in order to interpret the failures of previous policy.

A similar uncertainty marks the quoted passages with respect to future promises. Regarding the gap between claimed power and the actual control of the population’s health status, it is vital to observe how the quote establishes a programmatic association between a present situation, a set of rational means and the goals believed to be within reach. We should carefully observe that the first quote does not claim to really be able to produce the desired health gains, since the optimism is explicitly conditioned upon the acceptance of citizens; and this acceptance is not restricted to the passive compliance that is sufficient for many public policies to function. The future success of DK1989 and any other set of health promotion objectives rests directly upon the active participation of citizens, because their everyday behavior is the constitutive material of actual health improvements. What makes the composition of public health programs so demanding is precisely this breach between the overall responsibility for the population’s health and the lack of control over citizens’ health behavior.

It is the obligation of society to provide the basis for making the healthy choice easy; but even considerable efforts in the areas under the control of society cannot solve the health problems caused by the individual’s lifestyle (DK1989: p.11).

Knowledge about behavior and lifestyle diseases has not made the formulation of public health goals easier, as counter-intuitive as that may sound. Even though this knowledge is an open invitation for new policy, it also accentuates the incapacity of governments to fulfill the biopolitical care for the population that they assign themselves. In this sense, some of the goals set in DK1989 and similar documents are more like virtual goals saying what *could* be achieved if individuals were more responsible, but not necessarily something the Government believes it *can* realize.

DK1989 is also one of the few public health documents to have reservations about over-protecting individuals and invading their private sphere (DK1989: p.8). The social technology of reaching individuals and gaining their acceptance does not seem to have entered the rational reflection of Danish public health at this point, even though DK1989 does seem to adopt much of the rhetoric from WHO sources with this sort of rationality. For example, while DK1989 has a list of special risk groups, it does not include detailed knowledge about their particular risk profiles as the American US1990 did, nor does it seem to have developed any special strategy for reaching these groups. DK1989 claims to depend upon the 'acceptance' of its health policy objectives, but it is all but clear whose acceptance is important. Not until the subsequent Danish public health plan do we find the kind of systematic intervention strategy for socially disadvantaged subgroups that American public health has had since 1990.

We will return to the 1999 program later, but first we should observe the spatial arrangement of power relations in DK1989. We saw before how US1990 invoked a strong image of the Nation as the author of the public health plan, and while it is obviously not possible for an entire nation to actually draft a political program, it demonstrates the desire to involve the population in exercising power on its own health status.

The ambition to disguise the author of public health programs and the agent in power stems from the experienced powerlessness that has been documented repeatedly throughout this article. We do not yet know to a full extent whether the displacement is only a rhetorical cover for the failures of health promoting initiatives. If it is not, how will governments successfully be able to involve their citizens as active authors of their own health status, and if they can actually do this, what would such participation look like? The spatial arena in which DK1989 seeks to displace power is not the nation, which is not in discussion at all, but the Danish tradition for decentralized rule in counties and municipalities. In a publication drafted to accompany DK1989, the Danish Minister of Health Elsebeth Kock-Petersen explains the strategy:

In contrast to a number of other WHO members, Denmark is characterized by a large degree of decentralization, i.e. many decisions are taken by local authorities in municipalities and counties. Therefore, it is in complete accordance with Danish traditions that the government has not adopted any target programs to fulfill the goals of the WHO. Instead, the government has tried to *inspire* counties and municipalities to work with the goals (Ministry of Health 1989b: p.9; emphasis added).

This is a modest and indeed passive strategy, especially considering the unbridled optimism that is typical of this program in most other aspects. Some might argue that the American public health policy is not very far from this, given its division of power between federal government and the individual states, not to mention aspects of local government. The big difference is, however, that the American public health program US1990 does not seem to displace its biopolitical responsibility for the population's health. Rather, it can be argued that the singularity of American public health policy is overblown in the present documents in order to maintain the image of complete, national unity, but a correct answer to this speculation would necessitate a more detailed analysis than is possible here. The key point is that the ambition to inspire counties towards health promotion is also an attempt to displace the responsibility and involve more public and private actors in the authorship of public health.

If we widen the focus for a moment, the displacement of power relations in public health is not a completely new idea, although it did not enter Danish and American health programs before 1989 and 1990. Like many the most prominent elements in the new public health, the idea of displacing power relations away from the classical governmental hierarchy and the traditional organization of the health care sector also originates in the 1974 Canadian Lalonde report. Lalonde made a strong argument to replace the "health care system" as the center focus of health policy and spoke instead of "the health field" enclosing "all matters affecting health" (Lalonde, 1974: p.5). We have already discussed how Lalonde uses McKeown's historical research to devalue the contribution of medicine, and in accordance with this devaluation, the health field concept seeks to spread the responsibility for health. Besides health care organization, the health field includes everything from human biology and environment to lifestyle (Lalonde, 1974: p.31-33).

Although this expansion may sound reasonable in a descriptive sense, it does not make it any easier to design clear policy responses, if it simultaneously enlarges the group of responsible actors. If all parts of society appear as both authors

and recipients of health promotion, it will probably also make it much easier to hide the causes of policy failure. In any case, it is characteristic of all or most preventive public health strategies that they employ these incredibly expansive categories, both in terms of setting goals and placing responsibility. Both expansions resonate the critique of the traditional system of medical treatment as seen for instance in the Lalonde report where medicine is criticized for having too narrow a conception of health and of depriving citizens of responsibility for their own health status. Here we can see how a policy is essentially shaped by what it aims to depart from and not merely what it can do on its own merits.

To sum up, both the Danish and the American public health programs of the late 1970s defined their goals and responsible actors in a very broad sense. US1979 did conceive of the individual as surrounded by different environments, some with relevance to health, but no specific dimension of power or agency seems to apply to these environments. It might come as a surprise that public health programs of the 1970s appear to have the strongest form of individualism. Even if their description of the healthy individual is not particularly sophisticated, we would normally expect this period to reflect a more 'social' point of view. Hence, since the early public health programs do not reflect the sign of the times, it seems somewhat safer to have confidence in the present claim, which argues that technological developments aimed at the rational exercise of power is the governing principle of public health policy. The power relations of early public health policies were very poorly developed, both in terms of alter and ego so to speak. Despite the existence of broad concepts of health and the ideas of the Lalonde report, Danish and American public health policies could do no more than imagine health gains coming almost automatically from the government's transmission of healthy messages. Only the crudest philosophies of the Enlightenment would expect behavior to change so easily on the verge of new knowledge. We should note, however, that public health policy never abandons the Enlightenment vision, but the later programs do realize how much active shaping is needed to make individuals do what they know is healthy.

Public health policy had become more developed around 1990 than it was 10-15 years earlier. This is probably seen most clearly in the comprehensive American *Healthy People 2000*, which adopted an intricate combination of a national agenda tied to dedicated knowledge and intervention on the unhealthiest groups of the population. All documents of the middle period bear witness to the displacement of public health policy to include broader segments of society in the process of promoting health. The middle period maintains the dual experience of failure and

optimism, but in contrast to earlier, the spatial rearrangement allows public health policy to parcel out success and failure to isolated social segments.

The healthy settings of everyday life (1999-2005)

The Danish *Regeringens folkesundhedsprogram 1999-2008* (DK1999) marks the epitome of the country's political reflection in this field, in the same way that *Healthy People 2000* established a new threshold for the American policy. Of all Danish documents, DK1999 makes the strongest call for strengthening public health policy, and once again failure is the point of departure (DK1999: p.14). To be fair, DK1999 does not speak directly about the failures of past policies for the simple reason that all previous efforts in the area are plainly ignored. Yet, everything about the Danish health status screams failure according to the Danish minister of health Carsten Koch, especially median life expectancy:

[P]ublic health in Denmark is not developing in a satisfactory way. Since 1970 development in life expectancy in Denmark has not followed the development in our neighbouring countries. (...) Our life-styles are to blame – tobacco, alcohol, accidents, too much fat and too little exercise (...) There is a need for a change of attitude. It is no use just to make light of the question of health in Denmark by joking about the boring Swedes and the crazy American smoking rules (DK1999: p.5).

The Minister's words might leave the impression of a declining Danish health status, but this is not the case (on a general scale, at least). In fact, at no point in recent times has the Danish median life expectancy dropped, so the real problem in need of instant response is that Denmark has had the "lowest increase" among the countries compared (DK1999: p.14). During the 1990s, the Danish government authorized several successive commissions to monitor life expectancy, and this report is a response to the unpleasant results of these commissions (cf. Højlund & Larsen, 2001: pp.78-79). Regardless of how many times we have witnessed this already, it is absolutely striking to observe the unbridled optimism of yet another public health report. This optimism has been with us since the late 1970s, but back then, the optimism was to some extent 'free' because there were no real means to measure the success or failure of a given policy. Today, health programs are as saturated with monitoring and evaluation measures as any other political document subject to the imperatives of New Public Management. Against the backdrop of intensive benchmarking as well as the dubious successes of public health in the past, the optimism of DK1999 is still something of a puzzle.

One thing that clearly separates this program from its predecessors is its level of technical sophistication, especially in terms of securing the desired impact. An interesting thing to note is a distinctive ambiguity about political action:

Social and cultural norms are not easily changed by individuals who adopt deviating views or behaviour. They are rather changed through political messages and points of view supported by arguments and followed by action. It is necessary that the public sector acts, takes a stand and starts a dialogue on risks (DK1999: p.111).

Judging from the quote, we would expect changes in health to result from arguments in public discourse, collective action and all the other assets a democratic society has offer. The quote also displays a relatively strong call for political leadership, but the general idea seems to be that citizens can participate in the discussion. Yet, if we look at the following sentences, the new Danish public health program assumes a much more technical and instrumental viewpoint:

The most important tool of the public health program is the creation of *healthier settings* for every day life. Therefore, the program contains targets for an overall effort to develop the comprehensive systems that constitute the framework for everyday health behaviour so that this framework will provide for a healthier and safer life for the population. This concerns schools, the workplace, the local community and the health services. The physical framework, work routines and rules should be carefully studied and examined from the point of view of their negative or positive influence on health. Organised follow-up of such studies will yield outcomes that will gain in importance by being spread to other areas of social life for instance via the family (DK1999: p.111; emphasis in original).

Before we consider the impact of placing every day life in the spotlight of public health, it is vital to note the radically different approach to society and its citizens in this quote. Gone are all considerations of norms, opinions and arguments. The quote displays a perspective on the population's health in which all aspects of human life are mechanical objects to be scrutinized and manipulated like breeding animals or a military unit. It is a much more elaborate and systematic process of making social life the object of observation, calculation and control than we have seen in former health programs. Qualitatively, these ideas are old, however, because the quoted passage almost seems like a perfect recapitulation of the idea of a medical police. The surface of application is radically different from the old medical police (Rosen, 1993; Foucault, 2004a), especially if we take the previous quote about dialogue into consideration. It is a significant ambivalence in DK1999

that while it claims to build on democratic dialogue, it also promotes a surveillance strategy intervening into the population's everyday life, and bear in mind that the two quoted passages above appear on the exact same page in DK1999.

In terms of intervention, DK1999 uses a much wider selection of technologies, ranging from the softer measures like motivational conversations about smoking cessation to the stricter forms of 'securing' healthy environments around schoolchildren (DK1999: p.6). In contrast to previous Danish health programs that mostly wanted to 'inspire' and 'help individuals make their own choices' – which DK1999 still claims to do – the applied measures of 'securing' come closer to classical hygienic technologies such as quarantine and other severe technologies of the medical police. Because the various forms of intervention seem to point in several directions, for instance in expecting citizens to be active agents and passive recipients at the same time, DK1999 tries to integrate efforts in each area with the help of dedicated second order policies. Besides the usual categories like alcohol, smoking and drug policy, DK1999 also initiates an 'exercise policy', a 'sports policy', a 'nutrition policy', a 'hygiene policy', a 'bullying policy', and even a 'bicycle policy' (DK1999: p.52, 54, 55, 68, 81, 89). This health program builds on a strong belief in the creation of policies, a 'policy policy' so to speak (DK1999: p.112). It is a deliberate tactic of DK1999 to require workplaces, institutions, and local governments to adopt local health policies, not out of consideration for people's opinions, but because it creates greater compliance with the law (Larsen, 2002: p.291).

The displacement of power relations from central government is also present in the Danish case. Unlike the former Danish and American programs, DK1999 does not displace the exercise of power into one single entity such as the Nation or the People, but has a more comprehensive rationality of displacement. As the most general statement of displaced power, the following introductory statement by the Minister of Health, Sonja Mikkelsen, is illustrative: "Now we are transforming the government health program into the people's health program" (DK1999: p.7). Unfortunately, the quote does not translate well into English. The Danish word for public health – *folkesundhed* – literally means 'the people's health', so the Minister's word play turns 'the Government's people's health program' into 'the people's own health program' so to speak. The quote clearly demonstrates the ambition to put citizens in charge of their own health status, although it appears to be decided in advance how individuals should use their authority.

Similar to the American *Healthy People 2000* from a decade earlier, the ambition to include the entire country is strangely coexistent with a dedicated focus on specific groups and areas with unhealthy habits. In the absence of the racial dif-

ferences found in the American population, the Danish public health program aims specifically at the groups with the lowest income and education levels. The Danish approach in 1999 is somewhat more sophisticated in a spatial sense because it focuses specifically on the "healthy settings of everyday life", i.e. hospitals, primary schools, workplaces and local communities (DK1999: pp.80-100). It is essential here to notice the systematic displacement of power relations to surround the individual in its normal day-to-day life. This involves a two-edged take on communities, because DK1999 tries to disintegrate social relations that stimulate unhealthy behavior, while it has a clear intention to build healthy communities with the reverse effect (Larsen 2001: pp.80-86).³

If the Danish health program from 1999 seems closer to the decade-old American US1990 than to its 1989 predecessor, what happens when we turn to the latest American program, *Healthy People 2010*? There are no revolutions in American public health policy between 1990 and 2000, because the novelties are mainly in knowledge and evaluation measures. Hence, the US2000 introduction stresses the program's continuity with the past:

One of the most compelling and encouraging lessons learned from the Healthy People 2000 initiative is that we, as a Nation, can make dramatic progress in improving the Nation's health in a relatively short period of time. For example, during the past decade, we achieved significant reductions in infant mortality. Childhood vaccinations are at the highest levels ever recorded in the United States. Fewer teenagers are becoming parents. Overall, alcohol, tobacco, and illicit drug use is leveling off. Death rates for coronary heart disease and stroke have declined. Significant advances have been made in the diagnosis and treatment of cancer and in reducing unintentional injuries (US2000: p.3).

This statement of success stands somewhat in contrast to the Danish counterpart, which was mostly focused on the profound failure of public health policy. On the other hand, the statement also demonstrates an interpretation of success and failure that is quite similar to earlier reports from both countries. What is similar is how the specific areas now given credit for health improvements have little to do with lifestyle changes, for example teenage pregnancy and vaccinations, although lifestyle was where the previous report expected to see dramatic improvements. It is therefore unclear what qualifies the overall evaluation of "dramatic progress" when it is perhaps only five out of a hundred target indicators that actually meet the projected goals.

The point is not only that what counts as success or failure will always be a matter of interpretation, but also to notice that these reports systematically view prevention in a much more positive light than treatment, even when the highlighted success stories in the reports are as much about the latter. It seems almost ironic to quote improved cancer treatment as a success for the previous prevention report, when this report and its predecessor were built on the firm belief that the treatment paradigm had failed. This is also a point where the most recent public reports from Denmark and the US seem to converge. While DK1999 focuses more on failure and US2000 more on progress, the way they systematically attribute success to prevention and failure to treatment is the same. More interesting than specific successes or failures, then, is the systematic pattern by which the labels 'success' and 'failure' are assigned in the reports. The systematic pattern is what this article terms circular policy learning.

If we look instead at how US2000 compares with its American predecessors, there is a noticeable increase in complexity over time. While each successive document is more goal-oriented and more densely packed with measures and indicators than its predecessor, it is increasingly difficult to determine whether public health policy has the desired effect on the population's health status. No report in this analysis is more developed than US2000 in terms of measurement, health indicators and so on, but as we have just witnessed, the assessment of policy success and failure is still more or less arbitrary on a larger scale, because the many indicators are not really used to evaluate the policy, only to illustrate a more or less predetermined conclusion.

As we have already seen in the quoted passage, US2000 maintains the general focus on the Nation, which is still spelled with a capital N. In addition, the special focus on inequality in health and disadvantaged groups is still an essential part, although it does not seem to take up as much space and attention as it did in its Danish counterpart DK1999 or in the American predecessor US1990. This being said, there is a new dimension of spatial displacement in the most recent program that should be considered in this context.

Addressing the challenge of health improvement is a shared responsibility that requires the active participation and leadership of the Federal Government, States, local governments, policymakers, health care providers, professionals, business executives, educators, community leaders, and the American public itself (...) Healthy People 2010, however, is just the beginning. The biggest challenges still stand before us, and we all share a role in building a healthier Nation (...) Whatever your

role, this document is designed to help you determine what *you* can do – in your home, community, business, or State – to help improve the Nation’s health (US2000: introduction – 4).

One thing to notice is the repeated tendency to reel off a long line of responsible actors without a distribution of real authority; but the most important novelty of US2000 is the highlighted appeal to the indeterminate you. For the first time, a public health program speaks directly to the individual citizen, although it is unclear whether the program thinks normal citizens outside the circles of bureaucracy or the health care professions would actually read and try to live by the government’s latest health goals. In most other documents in this analysis, the success criteria are also some form of individual behavior, and in consequence, it might seem odd that the individual has never been addressed directly until now. Yet, there is a big difference between planning policy on the individual’s behalf and expecting them to read and adopt a 1,200-page health document. The authors of US2000 are probably more realistic than that, and the real point is probably to underline the role of the individual in the division of responsibility.

Conclusion

This article has argued that public health policies in Denmark and the United States have experienced a similar pattern of circular policy learning over the past thirty years. The assertion is not, however, that the population’s health status is similar the two countries. The populations are so differently composed in terms of age, race and class that if the policies converge in spite of these differences, health status is not likely to be the direct cause. Another possible explanation, which is often taken more or less for granted, is that the process of getting citizens to adopt healthier lifestyles is motivated by the fiscal constraints of the traditional health care sector. Although this may sound reasonable at first, the above analysis has demonstrated first of all that preventive public health policy constantly experiences a large degree of policy failure, so it is less likely that health care systems can save any money on this account. Second, the analysis has also shown that both the experience of policy failure and the simultaneous push for a more intense shift towards health promotion is more or less constant, which cannot be said for the fiscal constraints of the two countries’ health care sectors nor for the differences between the two countries.

We should ask instead what could explain this strange similarity and continuous experience of failure in Danish and American public health policy. This is not to say that we should look for a single, underlying cause, because the pattern of policy development we have seen above is not so much characterized by a constant, but rather by some sort of repetitive process in which public health programs are able to reinvent themselves again and again, and always in the company of unbridled optimism about how much health promotion can do to improve the health of the population. It is not the case that nothing changes at all, since both the technical sophistication and sheer magnitude of public health programs have increased considerably over the three periods covered. These changes, however, do not involve any real major policy shifts after the initial shift from treatment to prevention. Rather, the gradual elaboration of public health policies after the 1970s is a consequence of how they react to their own perceived powerlessness, which means that for each step of the way, the overall shift from treatment to prevention is reenacted at least on a rhetorical level, most often by reinterpreting the previous public health efforts as being bound up with the old medical paradigm.

On a theoretical level, this means that converging policies like the ones we have seen here should always be analyzed in relation to what they respond to, even if this policy response is sometimes overdramatized compared to how little the actual policy instruments and targets really change. This is how we can conceive of circular policy learning, and while all policy developments will bear some resemblance to what they emerge from, this is particularly characteristic of public health policy since the 1970s, because it evolves by continuously replicating a similar form of policy failure.

The present study points to the experience of failure and powerlessness in public health policy as the main generator of new policy ideas in the field. Of course, failure here does not mean that public health professionals or policy makers are incompetent in any way, only that the health reports themselves continue to experience the previous policy as failing. Lifestyle-oriented public health policy as it is constructed in the reports has a rather indeterminate relationship with its object, because it relies on the cooperation of individual citizens to improve their health behavior on a large scale. It is sometimes unclear whether it is the policy or the population that is said to be a public health failure, and to make sense of this uncertain situation public health policies surround themselves with virtual pasts and futures in order to reconstruct a sequence of events in which the health program suddenly appears to be in charge while its predecessor is said to have 'lost sight'.

The case of public health policy exemplifies the phenomenon of policy learning in the sense that all documents build on the impact of previous policy. It is also clear that an immense amount of collective ‘puzzling’ goes into the construction of the policy at each point, and since this process has a strong tendency to repeat the same arguments, it is best described as a case of circular policy learning. Again and again, public health policy is able to launch itself as a clear departure from the treatment paradigm and some of its alleged characteristics such as value neutrality, passiveness, top-down governing, and scientism. This is what a genealogist would call the construction of an *ursprung* – a false, linear origin whose job it is to hide the heterogeneous sources from which the present is derived.

Public health policy is also an interesting lesson about the relationship between biopolitical power and the resistance of individuals. All the quoted reports provide clear evidence that public health policies consider the entire life of individuals to be within their sphere of influence, and yet although everything is technically included, little actually seems to be under control. The political ambition to give individuals more responsibility for their own health is a two-edged sword seen from the point of view of health authorities, because giving individuals this power also gives them the freedom to be foolish (cf. Leichter, 1991).

Notes

1. To avoid confusion between titles and publication years, these six major policy documents are referred to by country initials and publication year, not title. Thus, Healthy People 2000 is referred to as US1990.
2. Parts of the empirical analysis draw on Larsen, 2009.
3. After the major cabinet change of 2001, the new government replaced DK1999 with Sund hele livet (DK2002). The latter program receives little attention in this analysis, simply because it lacks the independence and comprehensiveness of its predecessor and several parts of DK1999 remained in effect until its projected end in 2008. On most points, DK2002 is merely a shorter version of DK1999, but it adds a stronger focus on partnerships between individuals, civil society, and government institutions.

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