INVITED EDITORIAL

The interface between medicine and politics; an imperative and opportunity that should be used responsibly

Ashley Bloomfield

On a baking hot Sunday in February 2019, I joined then Associate Minister of Health Honourable Jenny Salesa and Children's Commissioner Andrew Becroft at a Weetbix TRYathlon in Point England, Auckland. At this event, the Minister announced the government's intention to legislate banning smoking in motor vehicles carrying children and teens under the age of 18.

I made a special effort to be present at this announcement for two reasons. Firstly, it was an important additional step in our ongoing efforts to reduce the impact of tobacco on health in Aotearoa New Zealand. Secondly, it had been around 15 years since the Ministry of Health had first provided advice to the government on introducing such a ban, and I wanted to mark the achievement and the tenacity of all involved. While the evidence for the benefits of such a ban had not changed over that time, the point had been reached where there was sufficient "social licence" to implement a ban: the political "window of opportunity" had opened to literally let in the fresh air.

For anyone who has worked in tobacco control, or indeed, public health more broadly, this will be a familiar story. All the changes in tobacco control that I have been involved with or observed over many years have required dedication and persistence on the part of many people to successfully navigate the political landscape. Public health, and medicine more generally, frequently operate at the political interface—in this case, the interface was with national politics, but it is just as likely in a workplace, professional organisation, local government body, or community.

This is hardly surprising, and indeed, not unique to medicine and public health. My personal definition of politics is that it is "what happens when you have two or more people in a room." In other words, politics is about the contest of ideas, beliefs, and opinions—it is part of our everyday human experience in homes and with wider whānau and friend groups, in workplaces, community organisations, neighbourhoods, etc.

The relationship between medicine and politics was astutely described by German pathologist and politician Rudolf Virchow in the 19th century:

> *"Medicine is a social science, and politics nothing but medicine at a larger scale. Medicine as a social science, as the science of human beings, has the obligation to point out problems and to attempt their theoretical solution; the politician, the practical anthropologist, must find the means for their actual solution."*[1]

Despite being a pathologist by training, Virchow is often described as the "founder" of social medicine—now more commonly known as public health, population health, or community health. His fundamental notion was that whole populations can be sick, or at risk of becoming sick, and that political action is sometimes needed to improve population health.[2]

What I find interesting in Virchow's quote is his comment about the role of politicians—that is, to "find the means for their actual solution." This resonates with the oft-quoted description of politics as "the art of the possible." It is one thing to point out the problems (easy—we are all experts at this) and have great ideas about how to solve them (also relatively easy), but much harder for politicians to successfully get people on board, and then ensure solutions are successfully implemented!

I've certainly found Virchow's description of politics very helpful over the last 20-plus years that I have worked in the wider public service. It explains how sustainable progress is made; often, the outcome of political negotiation is an agreement that is no single stakeholder group's full preference, but one that all stakeholders can live with *and* that can be successfully implemented. Compromise is not capitulation. A key point here is that politicians have a difficult job, and, as I've also learnt over the years, they all set out to make the best decisions that lead to the best possible outcomes.

Central to the work of public health is understanding the role of the broader environmental, social, cultural, and economic determinants of health and wellbeing. These determinants include access to safe water, education, income, employment, housing, access to cultural resources including land and language, safe neighbourhoods, and opportunities for active transport. All of these determinants are influenced by national and local government decision-making, policies, and funding. So, it is hardly surprising that public health action frequently lies at the political interface and can be seen as political in nature.

Addressing these determinants may bring public health professionals into conflict with powerful social and economic interests. Three of the biggest risk factors for non-communicable diseases, which account for much of the burden of disease globally, are tobacco consumption, harmful use of alcohol, and overconsumption of foods high in salt, sugar, and fat.[3] Private sector actors, including large, multinational companies that manufacture and market these products, have an interest – indeed an obligation to their shareholders – in maintaining or continuing to grow the market for their products.

Public health professionals working in advocacy have a different role to play in addressing the impact of these risk factors from those working in government roles. The latter must provide balanced and evidence-based advice on options to reduce the impact of these risk factors, while taking into account the wider costs and benefits of policy and regulatory change.

For those working in advocacy roles, championing public health causes is, at times, not for the faint-hearted. Public health professionals can find themselves provoking reaction and confrontation with other interested stakeholders. While social media present an opportunity to deliver public health messages and campaigns, they also provide a readily accessible platform for campaigns to counter, and even attempt to discredit, those seeking changes to improve public health.

Public health legislative or regulatory interventions sometimes impinge on people's rights and freedoms and there can be fierce debate as they pass through the parliamentary process. Yet, soon after their introduction, people can wonder why it took so long to implement them! One example, which I was involved with early in my career, was the introduction of Smokefree workplaces, including bars, clubs, cafes, and restaurants, in December 2004. Most of you won't have any knowledge of what it was like to come home reeking of smoke after an evening out; imagine what it was like for bar and waiting staff working there. As the (then) Ministry of Health lead for this area, I recall being quizzed by reporters as to who would "police" venues to ensure that smokers didn't light up inside once the new law came into effect. Of course, once the day arrived, smokers just went outside to smoke, and within a short period of time, most people—including smokers—strongly supported the new law.

Effective communication is essential to building "social licence" for change that requires political action. One of the most successful public health interventions during 2020 (and perhaps for some years) was open and clear communication with New Zealanders from the outset of the emergence of coronavirus disease 2019 (COVID-19) globally. Political and other leaders played a key role in supporting and championing a science-based response, and the clear and consistent communication of the government's decisions helped to build the trust and confidence needed to successfully implement radical interventions, not least a national "lockdown." A key piece of feedback I have received from the public was that people trusted the response in large part because those responsible for it didn't claim to have all the answers, and were honest when things didn't go right, or when they had changed their minds as new evidence emerged. This lesson is highly relevant to communication between health professionals and patients as well.

More broadly, medical and public health practitioners have played (and continue to play) a key role in advocating for changes to improve health and wellbeing and address inequities, especially between Māori and non-Māori. The understanding of people—individuals, families, and communities—that is a core part of the work of health professionals is highly relevant to the political process, as a key role for governments is to protect and improve the wellbeing of all people.

Medical practitioners are also often involved in the delivery of services where ideas and values are contested. Topical areas include taking a harm reduction rather than prosecutorial approach to drug addiction; the delivery of abortion services and the pending implementation of the outcome of the End of Life Choice referendum; and, of course, asking people to stay at home for weeks to help control the spread of COVID-19!

Finally, medical professionals have the privilege in New Zealand of receiving a medical education and training that are (still) largely publicly funded. With that privilege also comes a degree of political power (whether we seek it or not) and responsibility (whether we like it or not). A key responsibility is to ensure that the political power wielded by individual practitioners and professional medical organisations such as unions, colleges, and associations is used fairly and wisely. It can be used simply to commandeer resources for a service, specialty, or organisation, or it can be used for the wider good; keep in mind that "the only appropriate use of power is to empower others."

References

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