Considerations for Building a Population Health Movement: Five Key Debates

Merlin Chowkwanyun, MPH, PhD
Robert Wood Johnson Foundation Health & Society Scholar
University of Madison-Wisconsin, Department of Population Health Sciences
E-mail: chowkwanyun@wisc.edu
Web: ssc.wisc.edu/~chowkwanyun

Introduction

In the past two decades, the notion that medical care plays only a partial, and often limited, role in population health outcomes has become widely accepted among health researchers, even as they continue to debate the relative contributions of individual behaviors, socio-economic status, and the physical environment, among other influences. This work has generated a useful vocabulary, and speaking of “upstream and downstream” influences, “social determinants” and “fundamental causes of health” is now commonplace in scholarly circles (Braveman et al. 2011). A corollary and equally prominent branch of research has documented persistent health disparities between population groups, especially defined along ethnic and racial lines, and offered multiple explanations for them, ranging from accumulated day-to-day stress to institutional arrangements and public policies that result in unequal health risks (Williams et al. 2011). Whatever internal disagreements and nuances remain, there is little disagreement that health is an inextricably social, not just medical, matter.

Whether this population health perspective (Kindig 2007) has crossed academic borders into the policy world and general public, however, remains an open question. The debate around the Affordable Care Act (ACA) serves as one barometer and suggests limited success. ACA discussion has focused almost exclusively around expanding medical care access, with “health reform” becoming more or less synonymous with
“health care reform,” notwithstanding lesser known components of the ACA that address non-medical influences. This suggests a need for a more coordinated effort – a movement – to diffuse population health thinking into orbits beyond the scholastic.

But while declaring the need for a movement is easy enough, defining its exact contours is another matter altogether. Who will be its main participants? What will be its primary objectives? Will it constrain itself to stakeholders within health sector or aim more broadly? This brief will explore these issues via five interrelated key problems:

The first concerns desired outcomes, or put more simply: what is a population health movement trying to accomplish? What is the metric for success, failure, and everything in between?

The second addresses participation. Who exactly will be propelling the movement? Will it be primarily elite-driven and “top-down” or take on a more popular or “bottom-up” character? And what resources will it draw upon to further its goals?

The third considers political tenor. Should a population health movement push for fundamental transformations of current social configurations? Or should it be more ameliorative and try to work within existing practices? Will its overall character be one of conflict or consensus?

The fourth is the single-sector dilemma, that is, whether a population health movement should restrict itself to the health sector (defined broadly) or try to

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1 I have drawn heavily from the sociological and historical literature on social movements for this brief but have avoided grafting my discussion onto exact constructs used by the field’s scholars. In part, this is because unresolved debates and disagreements exist within it – much of it useful for the discussion that follows – and I did not want the brief to appear to endorse one camp over the other.
broaden its appeal to people or organizations with no initial or obvious interest in health.

The fifth, and final, item is coalition building, and what kinds of alliances, short- and long-term, will have to be built to achieve the movement’s desired goals. The next section of this brief will consider these in turn.

**Problem One: Identifying Concrete Goals**

Recent calls for a population health movement are hazy on concrete objectives, and more precision is necessary on what exactly such a movement would try to accomplish. One useful question to ask is whether a movement would primarily be a consciousness-raising endeavor or would go further and catalyze fundamental policy outcomes. The distinction is a useful one to make because some of the most prominent social movements in American history have not necessarily led directly to policy outcomes. Most of the general public and politicians of the time reviled the early abolitionist movement, viewing it as extreme and beyond the pale of acceptable mainstream discourse, and a so-called “gag rule” prevented discussion of anti-slavery petitions in the United States Congress from the mid-1830s to mid-1840s (Stewart 1996 [1976]). Rather, the movement’s importance was forcing the slavery issue, however slowly, onto the national public stage, setting in motion the events that eventually led to the formation of the new Republican Party. The late 19th-century farmers’ movement broadly referred to as populism similarly saw scattered success in the formal political sphere, especially at the federal level (Goodwyn 1978; Kazin 1995: 27-48). But it generated a political vocabulary that successfully captured widespread frustrations — even beyond the agricultural economy -- over economic inequality at the time, much of which
carried over to the Progressive Era and the New Deal eras a few decades later, long after the original populist movement had withered. Limiting a movement’s initial goals to diffusion of ideas -- in this case the population health approach -- may seem like self-constriction. But it can provide more focus and direction and be more realizable at this time. Altering the parameters of debate, in turn, widens the possibilities for actual institutional and policy transformation. Within health, the history of disease labeling offers many examples of this process. Sickle cell anemia and miners’ diseases, to name just two examples, achieved medical recognition after prolonged agitation first raised awareness of symptoms and then forced physicians, medical researchers, and policymakers to respond to human suffering by naming a problem and implementing policies to address it (Wailoo 2001; Nelson 2011; Rosner and Markowitz 1991; Derickson 1998).

If policy change does become a movement goal, whether at initial or later stages, identifying clear policy objectives will be necessary to avoid rudderlessness. (Disagreement about objectives -- and whether concrete objectives should even exist at all -- was one reason why much of the discursive shift generated by the recent “Occupy Wall Street” did not gain as much subsequent traction as it might have in the actual policy arena.) Some considerations for identifying and assessing targets will be discussed in more detail below, but they include level (local, state, federal, global), political realizability (amount of realistic support a policy can actually attain), efficacy (the relative benefits that would result if a policy were enacted), and form (whether by “policy” we mean strictly legislation or something broader, such as the institutional
practices of medical schools, local health departments, and community multi-sectoral coalitions).

**Problem Two: The Participation Question**

Population health debates have occurred almost exclusively in rarefied settings, namely academia, research institutions, non-profit organizations, and governmental bodies. This raises the question of *who* exactly will propel and participate in a population health movement, whatever its goals. The answer carries many ramifications. Movements shepherded mainly by professionals or experts can arouse suspicion and accusations of elitism and non-inclusiveness. At worst, too little input from broader constituencies, beyond policymakers and thought leaders themselves, can result in policies that fail to consider the actual needs of those they purport to serve. At the same time, a movement oriented around population health no doubt requires a certain amount of expertise, technical and otherwise, and this may be one reason why most of the contemporary debates about population health have occurred in more closed settings.

In a number of twentieth-century policy reform movements, a tension surfaces between top-down and paternalistic approaches and ones that are bottom-up and more inclusive or “grassroots.” Take, for instance, strides in sanitation and housing quality during the Progressive Era and into the middle of the twentieth century. These initiatives reduced and eliminated many health risks posed by the built urban environment of that period. At the same time, they were often planned and implemented in a top-down manner that ignored their human cost, as municipal officials deemed entire neighborhoods irredeemable cauldrons of disease and marked them for clearance, a practice known widely as “urban renewal” that targeted mostly immigrant and black
neighborhoods and continued into the 1960s (Roberts 2009). Still, however much we may recoil instinctively over more paternalistic and professional-driven movements, larger inclusion is a principle easier to support on paper than to realize in real-world practice. During the War on Poverty era, pilot programs mandated “maximum feasible participation” from “community” representatives, but who exactly the latter were and how much real input they should actually have on programs’ directions often became the subject of heated dispute (Chowkwanyun 2011). A more recent example of the tension comes from the 1980s, during the onset of AIDS, when lay activists, many recently diagnosed with the condition, challenged the process by which Food and Drug Administration (FDA) officials approved early anti-retroviral drugs like AZT (Epstein 1996).

Whoever the key participants, a movement also requires resources, and will thus need to consider what kinds it needs, in what quantities, and where it will attain them. Until recently, many social movement theorists focused heavily on resources in a narrower sense, defining them mainly in economic and political terms. This work focused on material pre-conditions necessary for movements to gain followings and take off. A more recent, and vibrant, branch of research, however, has criticized these older “resource mobilization” perspectives and underscored the importance of other types of resources: emotions, rhetoric, language, frames, stories, interpersonal interactions, social networks, and local cultures to explain the appeal and success (or lack thereof) of many movements (Goodwin, Jasper, and Polletta 2001; Polletta 2008). This new social movement literature complements the burgeoning literature in health communications research on appeals that do (and do not) resonate with the public, but more explicit
linking of the two bodies of work has been lacking. Given widely held, individually-centered beliefs about health in the United States and the limited exposure the population health perspective has actually gained with the larger public, careful attention to these latter aspects will be critical to the success of any future population health movement.

**Problem Three: Consensus and Conflict**

Many signal developments in the history of health reform – air pollution control, water fluoridation, and food and drug inspection -- have occurred because of consensus over their widespread and universal benefits. Others, however, have passed in the wake of sustained political protest and conflict. The formation of the Occupational Health and Safety Administration (OSHA) and the Mine Safety and Administration (MSHA) came only after decades of agitation from militant labor unions like the United Mine Workers of America (UMWA) and the Oil, Chemical, and Atomic Workers (OCAW) (Markowitz and Rosner 2002: 157-67; Leopold 2007). A population health movement will have to debate where it sits on a continuum between consensus and conflict. The answer, in turn, will determine what goals are more desirable to pursue in the current moment and which ones will have to wait until a more hospitable political environment exists for them down the line.

Many recent examples suggest that some amount of contention is unavoidable when it comes to health. The acrimony over the ACA, itself the result already of considerable compromise by President Barack Obama, is the most obvious illustration. But other examples exist, too, such as raging battles over food and beverage regulation, including taxes and proposed bans on high-volume sodas or trans fats (Nestle 2002); calls for bans on common compounds in household products, like bisphenol A and flame
retardants (Vogel 2006); and efforts to reduce or end completely end certain forms of energy extraction, such as mountaintop removal of coal, offshore drilling, or hydraulic fracturing (Palmer et al. 2010). All four of these examples potentially disrupt the status quo of influential interest groups.

Another particularly provocative example comes from a recent 2013 Institute of Medicine (IOM) report, *United States Health in International Perspective*, which notes better general health outcomes in states with stronger collective bargaining traditions and expansive welfare states, both of which have resulted in extended political conflict around the world, including street protests and rioting in some countries, particularly after the crisis of 2013 (IOM 2013). A population health movement, especially one in incipient form, will need to decide if it is worth tackling issues and aiming for policies that could result in considerable political resistance, or whether, at least in the beginning, it should adopt a more risk-averse and cautious course, opting to identify policies that appeal to the widest possible swath of people with the least potential political acrimony.

An additional axis for thinking through this problem (and problem two, the question of participation) is the insider-outsider continuum. Insiders (policymakers who hold official title) are often inhibited from taking positions deemed too radical and outside mainstream boundaries of debate. Outsiders, however, have much more liberty to adopt and advocate such stances, and a future movement will need to clarify insider-outsider roles. In the past, outsiders have served as a critical reference point that makes insiders’ stances appear much less extreme than might otherwise be the case. Franklin Roosevelt’s election and New Deal legislation passed, to name one example, during the peak and heyday of the American Communist Party and labor militancy in the 1930s,
Problem Four: The Dilemma of Single-Sector Advocacy

In 1946, the Textile Workers Union of America’s Solomon Barkin, declared that “deficiencies in basic living conditions . . . are the breeding ground for disease and poor health... No program for the improvement of the Nation’s health is complete which does not have the elimination of . . . deficiencies in basic living conditions . . . as one of its goals” (Barkin quoted in Fairchild et al. 2010). Barkin’s remarks suggested, in ways which would be more systematically captured by population health research decades later, that multiple domains influenced one’s health, including one’s housing and the ability to earn a sustaining wage. Given this panoply of influences, should a population health movement’s activities be primarily restricted to domains labeled as addressing “health” (a single-sector model)? Or should it move broadly, identifying health ramifications across domains without regard for formal labels and boundaries?

The advent of the “health in all policies” (HiAP) approach suggests the latter path is becoming most desirable. Who would not, after all, want to find ways to improve population health in as many sectors – whether labeled “health” or not – as possible? But real-world impediments to doing so may exist. Administrative boundaries, for one, sharply demarcate formal duties at all levels of government (Rigby 2011). For instance, while energy extraction contains enormous health ramifications, the Department of Energy’s duties are largely technical and infrastructural, and contact with the nation’s several health agencies is quite limited. Within academia, interdisciplinary work has experienced renewed traction, allowing health research to appear in departments where it
was previously not very visible, but balkanization of knowledge no doubt still exists within universities.

Context aside, single- and multi-sector approaches also carry inherent pros and cons that movement organizers must weigh. A multi-sector approach can be overly diffuse, spread resources thin, and lack the expertise and credibility of a single-sector alternative, wherein participants are often more well-versed in the details of a particular sphere than are advocates working in multiple areas at once. At the same time, there are many examples in the history of health organizing where multi-sector organizing has been critical. During the War on Poverty Era, the Office of Economy Opportunity sponsored countless experiments and policy initiatives that included housing, health, education, job creation, and early child development under a big tent (Orleck and Hazirjian 2011). Historically, labor and conservation movements provided considerable resources (monetary and human) for pushing through hallmark occupational and environmental health legislation, especially in the 1970s run-up to OSHA and the Environmental Protection Agency (EPA). The present-day environmental justice movement is an example of another multi-sector approach, one that unifies civil rights, environmental, and health advocates (Bullard 1990). At its best, multi-sector organizing greatly expands population health’s appeal and helps it avoid simply calcifying into a niche concern of limited interest. In the 1960s and 1970s, movement stagnation became an important factor when many quality-of-care struggles around hospitals and medical schools experienced a boom in interest that gradually subsidized without a larger base to sustain initial energy (Mullan 1976).
Problem Five: Creating Win-Wins and Coalition-Building for Population Health Policy

The dilemma of single-sector organization raises our final problem: identifying constituencies that might also support population health improvement, though perhaps not for the same rationales as people initiating a movement for it. Identifying such win-win “wedge” constituencies is crucial, as political bedfellowism has contributed to many social movements’ success. In the antebellum era, many northerners who harbored enormous racial animus nevertheless came to support stronger anti-slavery positions because of fears that the expansion of slavery would mean growing Southern power and a threat to northern white labor. The early 20th-century movement for workers’ compensation gained the support of many businesspeople who wanted to shift the costs of caring for injured employees onto the government (Rodgers 1998). Support for civil rights by politicians stemmed not only from commitments to racial justice but also Cold War concerns about the United States’s public standing on the global political stage. Many geopolitical rivals cited American racism in an attempt to undercut the nation’s moral authority to criticize the repressiveness of Eastern Bloc communism (Dudziak 2000; Borstelmann 2009). Political support for the Vietnam War fell not only because of street agitation but also internal dissent within the army and anger from Congressional fiscal conservatives over the war’s budgetary drain and economic consequences (Zelizer 2007). In a manner similar to these cases, a population health movement will likely have to find points of commonality with wedge constituencies if it is to catalyze a following beyond obvious supporters. Identifying allies within medical care may be especially
important, given the enduring “boundary issue” between medicine and public health that has existed throughout the 20\textsuperscript{th}-century (Brandt and Gardner 2000).

Any discussion of coalition-building requires one important caveat. While often political necessary, coalitions (and the compromises often associated with them) should adhere to clear principles outlining when they are acceptable and when they are not. After all, one of the most successful political coalitions of 20\textsuperscript{th}-century social policy, which led to the flurry of New Deal and Fair Deal legislation passed in the 1930s and 1940s, was also a Faustian bargain. Advocates of the Social Security Act and GI Bill, among others landmarks, acquiesced to a powerful segregationist Southern Democratic bloc, which pushed for local-level (and discriminatory) distribution of new funds and excluded entire swaths of the population from benefits. This in turn resulted in the denial of benefits to millions of African-Americans, with one leading scholar of the period writing that “new national policies enacted in the pre-civil rights, last-gasp era of Jim Crow constituted a massive transfer of quite specific privileges to white Americans,” one with residual consequences still present today (Katzenelson 2006). Although most coalitions do not result in as morally anguished and explosive a tradeoff as this one, it is important to consider whether adopting more pragmatic rationales for certain measures or allying with certain unexpected constituencies in the short-term may undercut other moral and ethical commitments.

\textbf{Conclusion: Population Health – Preventing Marginalization}

This brief has outlined five considerations to guide discussion on what a population health movement would look like. It urges those interested in seeing such a
movement to consider goals, nature of participation, political tenor, and strategic
direction, namely its relationship to non-health sectors and potential allies in coalitions.

Looming above these five points is a larger overarching question of why major
tenets of the population health perspective have become marginalized, revived, and then
marginalized again. After all, the idea that collective health outcomes are rooted in the
social is not new, and it is traceable (at the very least) to the public health enterprise’s
early Victorian roots in the 1830s and 1840s, when some of the very same boundary
issues above were actively debated (Hamlin 1998; Coleman 1982). Closer to the present,
future Surgeon General Julius B. Richmond co-authored a 1954 piece entitled, “Total
Health – A Conceptual Visual Aid,” which sorted the various influences of health into
three categories, the “emotional,” “internal,” and “physical” environments (Richmond
and Lustman 1953). “To balance the trend toward specialization and
compartmentalization fostered by rapid advances in the medical sciences,” Richmond and
his co-author wrote, “it is desirable to emphasize a comprehensive approach to the
understanding of man and his relationship to his environment in health and disease.”
They emphasized further that one should think of health as “dynamic relationships among
the multiplicity of types of forces operative upon and within the organism at any given
moment.” A decade later, Harold Light and Howard J. Brown, who founded one of the
first neighborhood health centers on the Lower East Side of New York, summarized the
facility’s underlying philosophy: “The patient functioned as part of a larger milieu – in
his own home and in the broader community – and these forces, therefore, must be take
into account if the service rendered was to be meaningful” (Light and Brown 1967). At
around the same time, in 1964, Kurt Deuschle, who would go on to a three-decades career at Mount Sinai School of Medicine, declared:

> Merely providing more health services or larger appropriations from the public purse without formulation of a new and more effective approach will not solve the long range health problems of these people. In short, when a community is as sick as this one, this sickness is reflected in the members of the society. An attack on the health problems of such an area must be combined with an attack on the social, economic, political, and educational ills if any solutions are to be permanent… What are the most appropriate public health and medical care solutions which society at large can afford to provide for such a rural slum neighborhood? (Tapp, Gazaway, Deuschle 1964)

In the early 1970s, the social demographer Thomas McKeown ignited a debate on the causes of the so-called epidemiological transition in the 20th century, where incidence of contagious disease and mortality declined precipitously in the advanced industrial economies, and examined the relative contribution of medical care against other factors, including better nutrition, sanitation, public health reforms, and economic development. The subsequent debate centered on the very issues that have captured the attention of population health science (McKeown 1976; McKeown 1979 [1976]).

Other examples abound. And to be sure, the recent research referenced at the start of this brief has examined these questions with undoubtedly greater empirical detail and conceptual clarity. But its core insight about multiple and non-medical influences on health is not new and remains strikingly similar to its predecessors. This suggests a phenomenon at work similar to what the social scientist Herbert Gans has called “sociological amnesia” in another context (Gans 1992). From the perspective of movement building, we should consider what causes periodic forgetting, then remembering, of the population health perspective, and try to sustain interest this time round.
REFERENCES

Short Glossary of Movement Terminology

Note: Considerable disagreement exists over exact definitions of these terms, and they should be only viewed as general and broad definitions written for non-specialists coming to the December 5, 2013 meeting from a variety of academic and practitioner backgrounds.

Social movement: A collective effort, usually by groups but sometimes by coordinated individuals, to make claims on states and private entities and/or spread ideas, beliefs, or practices among a population in the hope of achieving societal change. Social movements are frequently in tension or open conflict with a status quo.

Campaign: Although some may use “campaign” synonymously with “social movement,” the former might be better thought of as a tool for movement participants to use. It refers to attempts, usually public, to drum up support for a cause, claim, or idea, typically those underpinning a social movement itself. These attempts usually draw on slogans, visual symbols, and political motifs and are often waged via mass media, pamphlets, and other ephemera.

Frame: This term refers to the terms of debate and the parameters of discussion on which a discussion does (and does not) take place. Framing can also refer to strategic diction, choices of connotation, and special overtures to certain interest groups or specialized audiences. A conscious decision by policymakers to discuss education as a population health issue (or deciding not to do so) is an example of framing.

Grassroots: Though often deployed loosely, this term denotes a more informal, localized, democratic, and less rigidly structured and organized approach to political mobilization and social movements. Grassroots movements often include ordinary people without professional status or direct access to policymakers or elected officials, and they often work outside more formal channels.

Networks: The social, political, and organizational/institutional ties among people that can be mobilized in service of a social movement.

Narrative: This refers to storytelling, implicit and explicit, when movement participants’ try to amass support. They include both individual anecdotes to causal explanations of why phenomena like racial health disparities occur.

Resource mobilization: An older school of social movement scholarship that analyzes how movement participants marshal and utilize economic, political, and other material resources. A new generation of scholars has critiqued this approach and underscored the importance of narratives, frames, and emotional appeals, which are often as influential in determining movement momentum and ultimate success.

Further general reading:

