

Policy Challenges in Modern Health Care



EDITED BY

DAVID MECHANIC

LYNN B. ROGUT

DAVID C. COLBY

JAMES R. KNICKMAN

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Morality, Politics, and Health Policy

JAMES A. MORONE



American health care policy is different from health policy in other industrial nations. The United States has no national health insurance, of course. However, that difference simply reflects a deeper contrast in the ways we Americans think about politics and health care. European health policy analysts regularly invoke a "solidarity culture"—a staunch belief in sharing resources and concern for what might be called "the people's health" (Morone 2000). European political cultures and institutions often reflect this collective ideal.

What most observers first notice about the American process is the unabashed pursuit of self-interest. In our dynamic (some would say raucous) system, stakeholders and interest groups jockey for advantage on every issue. One wily nineteenth-century politician put it famously after double-crossing a rival: "Politics is not a branch of the Sunday school business" (Morone 1998). This process poses a challenge for health specialists: groups pushing their own interests will stand up and oppose even the most unambiguous scientific findings.

Both scholars and laypeople usually view health policy largely through the lens of interest group politics. Stakeholders and politicians pursue their preferences. They negotiate with one another, cajole neutral parties, and mobilize their own supporters. Constitutional rules bound this process, and an elaborate network of rights protects each individual. The entire political system lurches along, operating its celebrated checks, balancing public programs with private markets, blunting radical changes, and producing incremental adjustments to the status quo. From this perspective, health science constantly wrestles with self-interested politics. Even robust findings are only as good as the policy coalition that assembles around them.

However, interest group politics is only the most obvious story. Two other traditions run through policymaking in the United States. First, Americans also share an intermittent legacy of cooperation—one that grows especially vivid during a crisis. National service programs (such as VISTA and AmeriCorps), town hall meetings (often employed by political campaigns), and attempts to stimulate citizen participation are all familiar efforts to tap the American communal legacy.

Public health advocates, in particular, often try to move beyond competition and appeal to shared interests and values.

Morality offers Americans still another powerful political framework. As foreign observers often point out, the United States remains the industrial world's foremost Puritan nation (Morone 2003a). The Puritan colonists bequeathed America a tendency to turn political differences into moral disputes. The debates that gust up around our social programs often directly concern the moral worth of the beneficiaries: Are they deserving? Such questions put vivid and contested moral images—of virtue and vice, good and evil, us and them—at the heart of American health care politics and policies.

Traditional Models of American Politics

Individualism

Why are Americans so committed to individualism (or what political theorists call classical liberalism)? One of our great national myths offers a popular answer: the first colonists sailed away from old world tyranny and settled a vast “unpopulated” land—the place almost thrust freedom on them. American settlers did not have to push aside kings or nobles to get ahead. Instead, as Tocqueville famously put it, “Americans were born equal instead of becoming so” (Tocqueville 1969, 509; Hartz 1955; Greenstone 1986). Men (and maybe women; the myth gets a bit shaky here) faced extraordinary opportunities. The land and its riches awaited; success simply required a little capital and a lot of work. The irresistible result would be the nation's celebrated individualism, a deep faith in free economic markets (some foreign observers see almost a cult), and a corresponding belief in limited government.

The U.S. Constitution organized this ideology into the nation's political rules. An elaborate system of checks and balances limited national power. But this system also offered political participants many different venues in which to pursue their interests. In the past, political systems had tried to suppress self-interest; the American founders opened the door to it. The answer to the problem of factions, or interests, wrote James Madison in *Federalist* No. 10 (1787), is injecting an “even greater variety” into the political process. Today political scientists sometimes lament the hyper-pluralism of a system stalemated by competing claims, lobbyists, and lawyers. The practical result is that almost no political arenas stand above the scramble. There are only a very few nonpartisan agencies; there is no prestigious civil service trusted by all sides; and even the judiciary has become another political branch of government (McConnell 1966; Kersh and Morone forthcoming).

The sheer ferocity of this scramble for advantage poses a particular dilemma for health care policy. After all, medical science seeks objective answers to questions about health and health care. It documents, for example, the dangers of smoking, obesity, stress, unsafe sex, and delayed medical care. The surgeon general, the Institute of Medicine, and the Centers for Disease Control and Prevention might issue warnings based on good science. However, any effort to act on those findings simply triggers the politics of self-interest. No cultural mores penalize such

a reaction: in politics, economic self-interest is every bit as legitimate as medicine science.

The result appears to pose a conflict between medicine and politics. No matter how robust the scientific findings, political interests routinely mobilize and often delay or derail action. The politics of individualism offers health-minded reformers unambiguous advice: use your scientific findings to mobilize your own side. In the political arena, your science is only as strong as your political coalition.

Community

During the 1980s, critics began growing uneasy about unabashed self-interest and untrammelled markets. What happens to the common good when everyone pushes only for number one? Back to early America trooped the social theorists. There they discovered an entirely different American political tradition, one grounded in a robust collective life. In contrast to the legends of rugged individualism, historians documented rich networks of communal assistance. If a barn burned down, townsfolk banded together and helped their neighbor raise another. If iron pots were expensive, families shared them—early American household inventories often list one-half or one-third of a pot or skillet (Morone 2003a, 7).

The communal story sparks enthusiasm across the political spectrum. Here argue proponents, lies firm ground on which to imagine a renewed civic culture. Americans are not just celebrants of self but partners in a shared public life, not just individualists but communarians. Conservatives saw an opportunity to restore traditional American values; progressives stressed our obligations to one another, our shared communal fate.

For medical reformers, the legacy of community recalls an often-overlooked public health legacy. After all, American cities have a long history of funding clinics and fighting infectious diseases. A communal heritage—if it can somehow be tapped—opens the prospect of putting self-interest in a larger, civic-minded context (Putnam 2000; Skocpol 2003).

Franklin D. Roosevelt introduced his idea of social security with the classic communal appeal for public health. “The causes of poverty . . . are beyond the control of any individual.” So much for the individualistic version of American politics. What was the alternative? Community effort. When a modern civilization faces a disease epidemic, said Roosevelt, “it takes care of the victims after they are stricken.” But it also roots out the source of the contagion. Roosevelt proposed an entire social program built on the public health model. He would put aside the “jungle law of economic competition” for “brotherly” cooperation (Roosevelt 1932, 38).

Of course, President Roosevelt introduced his program in response to the Great Depression. The communal alternative has always been the more fragile and intermittent approach, displacing individualism largely during crises and extraordinary circumstances. Moreover, political theorists warn us against romanticizing the American communal tradition. After all, that tradition also animates a painful historical legacy: the urge to reject entire groups based on race, gender, ethnicity, or religion. The Ku Klux Klan, militia groups, and a long, harsh line of nativist organizations also represent communal thinking (Smith 1997).

Still, the communal vision offers a potential rejoinder to the politics of self-interest. Communitarians were critical of the Clinton administration's health reform effort, for example, because officials tried to sell it by promising one group after another that the plan was in their self-interest. The moral of that story, warned White House advisor Paul Starr, is that with "so many people on board . . . our boat may sink from its own weight." The communitarian perspective would have appealed bluntly to the common good—to the notion that we all share values as residents of the same nation (Hacker 1997, 138).

Could such a collective appeal work? Under what circumstances? What conditions stir America's communal legacy? And what about the ugly urge to reject some Americans? We can find answers to these questions in another tradition: American morality politics.

Morality Politics

Americans take religion and morality more seriously than citizens of most other industrial countries. Some 95 percent of all Americans believe in God—a distinct contrast to Sweden (52 percent), France (62 percent), and Britain (76 percent). While other industrial nations grow secular over time, the United States keeps experiencing religious revivals (Morone 2003a, 22). That social fact has deep consequences for U.S. politics. In a nation marked by moral and religious fervor, partisans often import their faith into politics.¹ Moral fervor drove—drives—an extraordinary range of political movements: civil rights, temperance, tobacco, anti-abortion, and many others. Moral judgment seeps into all kinds of political issues in both dramatic and subtle ways.

Moral politics comes with its own founding story. "It seems to me," wrote Alexis de Tocqueville, "that I can see the entire destiny of America contained in the first Puritan who came ashore" (1969, 279). Those first settlers arrived in the New World facing the essential communal question: Who are we? Who were they? The Puritans concocted an extraordinary answer: they were the community of saints. Leadership, in both state and church, went to men who could prove that they were preordained for salvation. The saints could vote, hold office, and enjoy full church membership. (The methodology for proving salvation was complicated, but wealth and health were taken as fairly reliable indicators.) People who were morally uncertain—those who had not demonstrated salvation—were expected to follow the proven saints: they went to church, for example, but did not hold office, vote, or become full church members. And the damned were driven out: witches were hung, Native Americans slaughtered, and heretics sent packing (mainly to Rhode Island, the latrina of New England for all its noxious heresies). In short, moral standing defined leaders, allocated privileges (such as voting), defined communities, and identified the dangerous "other" (Morone 2003a).

The Puritan idea burst out of New England and spread across America (thanks to the purest Puritans, the Baptists). The essential Puritan trope still persists and flourishes: moral virtue continues to define the community, still distinguishes "us" from "them." Moral images specify privilege or punishment, inclusion

or exclusion, deserving poor or dangerous other. These images of potential beneficiaries—often shifting, constantly contested—lie under every U.S. social policy. "We" get assistance; "they" face social controls.

The traditional individualist model of American politics emphasizes a sharp line between private realm and public sphere. Constitutional rights bar any public authority from meddling in people's private lives. "However strange it may seem," wrote John Locke in 1689, "the lawgiver hath nothing to do with moral virtues and vices." In this view, citizens draw on their private desires and values and then charge into the public, political realm to advance their goals. In the patois of economics, every agent maximizes her own utilities (Locke quoted in Morone 2003a, 6). In contrast, moral politics refuses to honor the private-public distinction. It explicitly enters the private sphere. Individual virtue—character—affects the public good. Citizens' private behavior, ruled right out of politics in traditional models, now becomes crucial. Some group's private behavior (real or imagined) seems to threaten the community.

The Puritans bequeathed the United States two distinct moral visions, two answers to that political bottom line: Whom should we blame for our troubles? I call the two answers the Puritan and the social gospel.

Puritans

The Puritan approach focuses on dangerous sinners lurking in our society. The fears tilt political debates; they sink the communal urge by eroding our sense of common values and shared fate. The policy problem turns instead to protecting us from them.

The personal transgressions—the sins—that ostensibly endanger the nation are most often public health sins. For example, the most sustained moral campaign in U.S. history targeted substance abuse. Temperance crusaders organized in the early nineteenth century, won their first statewide prohibition in 1851, managed national prohibition by 1920, and now inspire a formidable drug war that draws heavily on Prohibition-era jurisprudence (Morone 2003a).

Sexual threats pose another political perennial. The American Medical Association launched its first great political campaign against abortion—a common practice in the mid-nineteenth century, when roughly one abortion occurred for every six live births. Physicians consolidated their own role as social leaders and healers by turning abortion into a crime. Abortions, they argued, were subverting the good community by undermining the white, middle-class birth rate while foreign immigrants multiplied and threatened to swamp American blood (Storer 1867; Morone 2003a).

Similarly, sexually transmitted diseases bred in the urban ghettos and spread into middle-class families. After all, reported the *American Journal of Public Health*, "many . . . white . . . boys are going to sow their wild oats" (Allen 1915, 200). In the South, the black syphilis rate became a standard justification for Jim Crow apartheid. A similar argument reappeared during the first wave of AIDS hysteria; frightened Americans dreamed up all sorts of ways to keep homosexuals from slipping their disease into mainstream culture (Morone 1997).

In each case the same general pattern recurs. Some dangerous personal behavior—drinking, drugs, sexual practices, teen pregnancy, birth control, abortion, the list goes on—threatens the community. The questionable behavior is often associated with some group. Moral politics triggers vibrant stereotypes: Irish drink, Italian immigrants have too many babies, Muslims are terrorists, and black people commit almost every possible sin. Political leaders warn that America faces terrible decline if we don't find a way to rein in the dangerous people and their bad behavior. Standard solutions run to pledges ("just say no" to alcohol, drugs, and sex before marriage), prohibitions, restrictions, regulations, more prisons, and tougher laws.

Of course, all societies impose controls. The political key lies in the emphasis on personal discipline, in the balance between restrictive policies and social welfare benefits. I experienced a vivid illustration of the difference during a debate on the Clinton health reform proposal in 1994.

I was debating a Republican senator who opposed the Clinton plan. We were before a young, liberal audience that was giving the Republican a very chilly hearing. Then, toward the end of the debate, he abruptly turned to face me. The body language said, "Okay, let's quit kidding around." And here's what followed: "Look, professor, you can't expect the hardworking people of suburban Cook County to go into the same health care alliance [a kind of insurance pool] as the crack heads in the city of Chicago." When I turned to face the audience, all set to brush aside this fatuous dichotomy, I saw a room of suddenly sobered liberals. "Yes," they were thinking, "that is a terrible problem." "Hey," I yelled, "those uninsured people in the city of Chicago are college students and hardworking nurses and taxi drivers doing double shifts and single moms holding down two jobs." No dice. In fact, it only got worse. Crack heads and single moms. Our imagined community, struggling together to fix a troubled health care system, had vanished in an instant. Now it was a hardworking us against a drug-abusing, sexually promiscuous them. Forget about extending health care coverage—what "those people" need is moral discipline. The politics of social policy always turns on the mental images we create of the beneficiaries (Morone 2003a).

The Social Gospel

An alternative moral tradition once offered a sharp alternative to blaming individuals. I call it the social gospel (borrowing from a group of reformers at the end of the nineteenth century). Social gospel thinking shifts the focus from individual sinners to an unjust system. The neo-Puritans blame individual misbehavior for society's troubles; the social gospel approach blames society—or socioeconomic pressures—for individual troubles. The causal arrow runs in precisely the opposite direction: the economic system, race prejudice, underprivilege, and social stress put pressure on people. If those people behave badly (by using illegal drugs, for example), it is largely because social and economic forces have pushed them into a tough corner. The social gospel solution appears in countless variations, but they converge on the same familiar points: fix the system and give

every American a fair chance to prosper; don't blame those who fall by the way-side; we all share a common duty to help the disadvantaged.

Thinkers in the late nineteenth and early twentieth century first systematically articulated a version of the social gospel. Reformers like Jane Addams began challenging the dominant Victorian paradigm: poverty caused drunkenness, they said, as much as the other way around. Low salaries and harsh factory conditions—deprivation, not depravity—pushed women into prostitution. This way of thinking came to power with the Roosevelt administration in 1933.² Roosevelt constantly articulated the social gospel, and his administration hammered out policies that reflected that approach. The social gospel, like the Puritan perspective, turns on images of health and disease. However, while the neo-Puritans tend to fear contagions, the social gospel seizes on community health as a public policy model.

Roosevelt first introduced the idea of social security while campaigning for president in October 1932. Roosevelt began by declaring that because it was Sunday, he would not be "talking politics" but "preaching a sermon" (Roosevelt 1932, 38). True to his word, the candidate packed his address with religious quotations and allusions. As I noted, he used a public health analogy to draw a picture of the good society, one that protected the weak and the disadvantaged.

Roosevelt brought these generalities down to political earth with sad stories about good people. An 89-year-old neighbor had died while milking a cow, after a blizzard no less; now it was our collective responsibility to help his "83-year-old kid sister," who was languishing in an insane asylum because she had nowhere else to go. Roosevelt was off and running down a roster of needy innocents who needed help: hungry children in public schools, injured workers, sick men and women, crippled children, the unemployed, and many more (Roosevelt 1932, 38). Each example came with the same political spin: poor people are virtuous neighbors who have fallen on hard times. Roosevelt was consciously displacing the past icons of depravity—undisciplined black men and lazy immigrants lounging about the saloons.

That last example, drinking, carried plenty of baggage, for these were the last days of Prohibition. In the New Dealer's hands, excess drinking turned from sin to illness; dry pledges and national prohibition gave way to treatment and education. The fault line between neo-Puritans and social gospel would run right through the next half-century: vice versus illness, crime versus public health, sin versus social responsibility. The social gospel view reached its high tide during the southern civil rights movement and the Johnson administration's Great Society. "Should we double our wealth and conquer the stars," declared Johnson in his most beautiful speech, "and still be unequal to this issue [of racial inequality] then we will have failed as a people and as a nation. For with a country as with a person: what is a man profited, if he shall gain the whole world, and lose his own soul?" (quoted in Morone 2003a, 426).

The Reagan administration eventually buried the whole approach. Reagan scoffed at the idea of collective responsibility. Instead, he turned personal responsibility

—just say no—into a formidable policy mantra. Today the old social gospel idea that drug abuse or crime might stem from underprivilege finds almost no policy traction. Contemporary politics includes plenty of moralizing, but there is scant evidence of the old social gospel idea that we share a collective responsibility to foster social justice for everyone.

Moral Politics in Action

Morality politics are protean and pervasive, springing up in unexpected places and surprising unwary policymakers. Consider two recent cases: school health centers and the politics of obesity.

School-Based Health Clinics

Difficult health problems such as substance abuse, reproductive health, and depression can land teenagers in serious trouble.³ Given the nature of these problems, perhaps it is not surprising that they are slow to seek care. However, ignoring adolescent health leads to serious problems: one million unintended pregnancies a year, three million sexually transmitted diseases, more than four thousand suicides, and terrible incidents of school violence. The United States has a high adolescent and young adult death rate: 1.5 deaths per thousand young males (in contrast to 0.7 in England, 0.6 in Sweden, and 0.9 in Germany).

One policy response that grew increasingly popular in the 1990s sprang from a simple intuition: put the health care where the kids are. Local hospitals, community health centers, and public health departments opened health centers in schools, especially in poor neighborhoods (Morone, Kilbreth, and Langwell 2001).

Across the country school-based health centers immediately set off a political storm, as they inevitably faced issues such as substance abuse and reproductive health. Cultural and religious conservatives feared that providing treatment (possibly without parental notification) would implicitly condone illegal drug use, underage drinking, and premarital sex. Conservatives countered with calls for stronger discipline, personal responsibility (just say no), and abstinence education. By 1997 the Personal Responsibility and Work Opportunity Reconciliation Act (the welfare reform bill) had introduced abstinence education in schools across the United States (Morone 2003b).

Some liberals confronted the moral issues head on, responding that young people needed counseling on sexuality and chemical dependency. If teens were going to have sex, argued these advocates, they ought to be prepared. Dr. Jocelyn Elders set off a firestorm in her first press conference as director of the Arkansas Department of Health: "We are not going to put them on their lunch trays. But yes, we intend to distribute condoms [through] . . . school based clinics" (Elders 1996, 242).

The battle was on. However, liberals soon discovered that cultural (often Christian) conservatives had formed powerful local organizations across the nation. Those groups focused, in particular, on school boards. In the Northeast conservatives found allies in the Catholic bishops, who were chary of birth control.

In the South and West conservatives acted with the Christian Coalition. In the Pacific states they allied with anti-tax advocates. When the Christian Coalition helped Mike Foster come from far behind and win the governorship of Louisiana, the organization's first demand was an end to the school health centers.

Parental notification posed another difficult issue. When the California legislature passed a bill guaranteeing privacy in school health centers, critics charged the government with undermining parental control. More than ten thousand people rallied against the bill, which conservative talk-show host Dr. Laura turned into a highly publicized cause. Governor Gray Davis responded by vetoing the legislation.

Yet despite ardent opposition, the clinics survived and flourished. Even the school centers in Louisiana weathered the storm and spread. How? Proponents turned moral politics into a classic interest group issue. Where cultural conservatives opposed reproductive health services and sex education, the centers backed off, usually referring their student patients to other providers. But more important, advocates employed that classic political wisdom: build a constituency. As children started receiving treatment, parents, teachers, and health providers rallied around the centers, countering moral complaints with down-to-earth descriptions of kids getting care.

These respectable locals—parents, teachers, and health care providers—told their legislators heartwarming stories about children and the school clinics. Legislators are always primed to deliver concrete benefits to "responsible" community members, and school clinics have proven a prime constituent service. They combine education and health care. They do not bust the budget. They are simple to understand. They offer fine photo opportunities. And they can be doled out one school at a time (Morone, Kilbreth, and Langwell 2001).

In the end the health centers overcame the opposition and expanded, from some 150 in 1990 to more than 1,300 today. But both sides of the story are important. Although advocates defused the moral attack, the criticism powerfully shaped both the health centers and their politics. The health centers reflect the larger politics of public health. Reviewing the response to AIDS, for example, the *American Journal of Public Health* (AJPH) reported that Americans engage in far more premarital sex than their British counterparts while condemning promiscuity at much higher rates (Morone 2003a, 481–482). The colonists still adhere to the old Puritan spirit, chortled the *Economist*, reporting on the AJPH survey, and they pay the price (Morone 2003a).

American public health policies must steer carefully between sin and censure. When AIDS hit, the more tolerant and abstemious Europeans quickly launched forceful public health campaigns that included leaflets, television advertisements, and needle exchanges. Across the Atlantic, Americans delayed their efforts while squabbling over the exact moral nuance of their message, particularly the degree of emphasis on abstinence. U.S. incidence of AIDS soon measured ten times higher than Britain's (Morone 2003a, 481). Of course, many factors underlie such differences, and, as with the school health centers, Americans eventually sorted out the tension between education and abstinence. But moral conflict again profoundly shaped the health program and its outcomes.

Obesity

In 2001 Surgeon General David Satcher issued a startling report: over 65 percent of Americans were overweight and 30 percent were clinically obese.⁴ Obesity, rising at epidemic rates, threatened to overtake tobacco as the chief cause of preventable death. Americans (in fact, residents of almost every nation) suddenly found themselves bombarded by data on obesity's toll—on our lives, our health, and our budgets (Kersh and Morone 2002a).

The issue first provoked derisive commentaries about “big chocolate” and its “menace.” The critics drew on the familiar model of America as a nation of individualists who celebrate free markets and vehemently oppose government meddling in private lives (Kersh and Morone 2002b). What could be more personal than the food one eats? The critics were pointing to a genuine dilemma. How might eager public health advocates make a political issue out of such a private matter?

One classic response lies in the moral realm. Nothing moves the political system like a threat from greedy companies who put profits before the public's welfare. Demonizing providers regularly offers reformers a way to cross into the private sphere and control, limit, or prohibit. In the early twentieth century, temperance advocates gained considerable political mileage by charging breweries and saloons with pouring poison into the American workingman. Tobacco offers a more contemporary example. Public health officials spent years trying to publicize the danger, but for political effect nothing matched revelations that the industry had consciously misled the public about the health effects of smoking.

The same kinds of condemnation rapidly entered the obesity debates. Public health scholars explain the startling rise in obesity by pointing to an “unhealthy food environment.” For starters, portion sizes have undergone an extraordinary expansion. In his influential book *Food Fight*, Kelly Brownell describes the growth of the all-American burger. In 1957, he reports, the typical hamburger weighed in at one ounce and 210 calories. Today that burger is up to six ounces and 618 calories—and that's before the bacon, cheese, supersized fries (another 610 calories), and double-gulp (sixty-four-ounce) soft drink (Brownell and Horgen 2003, 183). Highly competitive food service entrepreneurs trumpet ever-larger portions: think Whopper, Xtreme gulp, Big Grab, and the Beast. Each innovation ups the ante in serving sizes. Even ostensibly healthy products come loaded with hidden ingredients: sugar (or high-fructose corn syrup) is the first ingredient in Kellogg's Strawberry Nutri-Grain yogurt bars, and the second in Skippy super-chunk peanut butter (Brownell and Horgen 2003; Nestle 2002; Kersh and Morone forthcoming).

Moving from these analyses to charges of corporate villainy required only a small step. As the most ardent critics put it, a cynical industry targets children and reshapes their eating habits. These companies put soda machines in schools and fast food outlets in lunchrooms. The result, argues Eric Schlosser in *Fast Food Nation*, is “a lifetime of weight problems” and “emotional pain.” And that is just the beginning. Fast food, he continues, has trashed the countryside, widened the social gap between rich and poor, and turned the meatpacking industry into a labor nightmare (Schlosser 2001, 240). Schlosser's descriptions of the food business are every bit as horrifying as Upton Sinclair's famous expose *The Jungle*.

Schlosser's book became a surprise bestseller, and a steady stream of exposes rapidly followed.

One backlash against fast food muckrakers simply shifts the blame. If some liberals demonize the industry, some conservatives blame overweight individuals. Heavy people lack willpower, they make foolish food choices, they live in unhealthy ways. Like smokers, drug abusers, and heavy drinkers, obese people have made personal choices; they should just say no and push away from the table. The distinct echo from other substance abuse controversies has another unhappy parallel: obesity tends to concentrate in poor and minority communities.

Each picture of blame—the industry versus the individual—carries different policy implications. A focus on the industry suggests requiring better food labels, rethinking school nutrition, restricting advertising, regulating fat content, punishing misleading claims, taxing unhealthy ingredients, and so on. Successfully demonizing big food—directing popular anger at the industry—may cut through the checks and balances of the political system and provoke action.

However, the politics of demonization cuts two ways. Some observers charge that food stamps and school lunches only encourage poor people—who are already fat enough—to overeat (Kaufman 2003). Others have suggested an insurance premium tax on heavy people. Once policymakers begin condemning heavy people, the list of possibilities rapidly grows.

The larger lessons from America's long moral history suggest that demonization is always tempting, since it gets political results, but always dangerous: it fractures communities, limits the range of health policy alternatives, and tends to land hardest on poor and weak populations. In the long run, public health advocates do best when they focus on policies that foster healthy lives and build strong communities.

Past efforts to regulate private behavior, such as alcohol and tobacco use, also take us completely beyond politics and into the cultural realm: Americans dramatically reduced their drinking, their smoking, and even their tolerance for secondhand smoke. When advocates detect a crisis, define a problem, and seek a solution, they are—indirectly, perhaps often unexpectedly—educating the public. The obesity wars are likely to grow, spread, and generate considerable political heat. However, if the history of drinking and smoking serve as a guide, the most important result may lie in the conclusions that citizens draw about their own lifestyles (Kersh and Morone forthcoming).

Epilogue

Moral fears and aspirations profoundly affect American politics. Franklin D. Roosevelt and Martin Luther King made moral arguments as they redefined American social policy. President Ronald Reagan asserted a very different moral framework: neo-Puritan rather than social gospel. The force with which he championed his alternative, and the success he met, may be his most enduring domestic legacy.

When it comes to moral politics, every side seizes on health care. The Puritan approach focuses on threats to public health: drinking, drug abuse, out-of-

wedlock births, sexually transmitted diseases, and more. Fears often lead to powerful public action: to restrictions, regulations, and prohibitions.

Proponents of the social gospel alternative reframe the problem away from sin and sinners. They see illness rather than crime, addiction rather than moral weakness. They would treat rather than punish; they look past personal behavior and focus on complex social causes. They constantly echo Franklin Roosevelt's Sunday sermon on social security and call for public health solutions. Puritan drug wars elicit social gospel calls for treatment, education, and harm reduction. More broadly, social gospel pushes for social justice; it promotes collective responsibility toward all members of the community. However, today's call for social gospel programs is only a weak echo of the powerful reforming tradition that dominated American politics in the 1930s and 1960s (Morone 2003a, 407).

Still, down through American history and across a wide political spectrum today, every side uses images of health to articulate its hopes and aspirations, to voice its fears and warnings. The problems we face and the solutions we contrive ultimately revolve around our definitions of health and illness and the pictures we construct of one another. In the end, American morality politics simply reminds us of the importance—the cultural power—of health, health care, and health studies in forging a good society.

Acknowledgments

This chapter is based on my book *Hellfire Nation: The Politics of Sin in American History*. I am grateful to Rogan Kersh and Elizabeth Kilbreth, my collaborators in studying obesity and school health care centers, respectively. Finally, thanks to John Dilulio, Steve Macedo, Gretchen Ritter, Deborah Stone, Rick Valley, and Sandra Hackman.

Notes

1. People often ask me about the constitutional separation of church and state. In fact, that is precisely what fostered the American religious tumult. By keeping government out of the religious sphere (and refusing to privilege any one sect or faith), the Constitution facilitates robust competition—precisely what makes the American religious culture so fluid and vital.
2. Historians would not categorize Roosevelt with the social gospel thinkers. I have redefined the category around its most salient features and applied it more generally. For details, see Morone 2003a, part IV.
3. This discussion of school centers comes from work I have done with Elizabeth Kilbreth. We are grateful to The Robert Wood Johnson Foundation for funding the research.
4. My discussion of obesity is shaped by the insights of my collaborator, Rogan Kersh.

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