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The political economy of public health

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In the spring of 2020, civilization briefly came to a near standstill as the world watched and anticipated, with trepidation, the potential catastrophe that might unfold from the viral outbreak now known as COVID-19. During this time, governments around the globe instituted unprecedented policy changes meant to slow the spread of the disease. Given the rapid onset of the contagion and the extreme medical and epidemiological uncertainty surrounding the pandemic, direct pharmaceutical interventions were limited. Early responses, instead, were "non-pharmaceutical" (Perra, 2021). They included event cancellations, school closures, shelter-in place orders, travel bans, remote work, curfews, and limitations on social gatherings. While some of the policies were fostered exclusively through private, voluntary institutions, many were sponsored or directly enforced by coercive, political means. The unprecedented use of state intervention in response to infectious disease provoked a host of questions concerning the role of the state and the political economy of public health.

A recurring question centers around the structure of institutions. What constitutes a health-related public good, for example, is not institutionally neutral—it depends, indeed, on the rules structuring our social, political, and economic interactions. Political institutions are of particular interest, given the potential for opportunistic behavior. What incentives do those institutions foster? Furthermore, what sort of epistemic properties characterize public health institutions? From where do contemporary public health institutions originate? And how might we expect them to evolve following the COVID-19 pandemic? Public choice scholars often tackle such questions by asking what sort of rules might enhance the level of institutional robustness—especially in the face of rapidly changing conditions, such as a health crisis. Each of these questions is taken up by one or more of the following authors.

Leeson and Thompson (2022, p. 2), in the opening article of this symposium, write that "public choice scholars have attended only modestly to issues in public health". And while the authors cover a great deal of economic analysis conducted prior to the COVID-19 pandemic, the weight of the preceding scholarship does not measure up to the size and scope of contemporary public health institutions, which have grown to occupy a sizable seat at the political table. Political economists in many ways were caught off guard in the spring of 2020. The articles contained in this issue were collected in the spirit of redress, with the hope that each contribution might facilitate further contributions to fields broadly

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conceived under the umbrella of "the political economy of public health", better preparing future generations of scholars for engagement in serious scholarship and policy discourse.

Leeson and Thompson make an important initial contribution to the symposium by taking stock of the work on public health from the perspective of public choice. They highlight three main themes that emerge from the literature predating the pandemic. First, public health regulations often are driven by private interests—not public. Second, the allocation of public health resources also reflects private interests—not public. Third, public health policies may have perverse, unintended outcomes that undermine their stated goals. That observation should come as no surprise to those familiar with the "government failure" analogue to market failure. Their review offers a convenient and useful summary of past investigations for future scholars in the field.

The private–public distinction in public health policy is taken up by Anomaly (2022), who argues in favor of relegating public health to those types of goods and services that constitute genuine (or "pure") public goods. Anomaly goes even further in excluding certain goods from the domain of public health by way of what he calls "the conversion problem". Through conversion, governments transform what otherwise would have been a privately constrained choice into one of public concern. Thus, even if one agrees that public health should be confined to the provision of genuine public goods, what constitutes a "public-health public good" is in constant flux depending on the nature of the health hazard we face as well as the surrounding rules and institutions that influence human behavior.

Similarly, Albrecht and Rajagopalan (2022) question the economic rationale behind COVID-19 vaccine mandates. Like most vaccines, COVID-19 vaccines protect individuals against the most severe symptoms of the virus. However, unlike other vaccines, it does not prevent viral contagion. The benefits of vaccination, therefore, are uniquely concentrated on the individual, rendering most COVID-19 externalities *inframarginal* as opposed to marginal. Insofar as externalities exist, they are Pareto-irrelevant (Buchanan & Stubblebine, 1962). The authors further maintain that existing externalities are confined to one's immediate network and community, requiring a local rather than a global public health response, despite the push for universal vaccine mandates among public health policymakers.

Congleton's (2022) contribution bolsters the economic justification for more local public health policy. Given the innumerable margins of variation among individuals (altogether distinct from the properties of the virus itself), it should come as no surprise that the "best" policies tend to emerge differently across locations, time, and among different groups. Still, policies commonly endorsed by health professionals during the COVID-19 pandemic took insufficient account of the variation. In addition to his positive economic analysis, Congleton argues that policy variation is normatively desirable because it allows for different groups to make particularistic tradeoffs according to their unique needs and encourages experimentation among different policy approaches. "Ideal" pandemic policies, he concludes, are more likely to emerge from a polycentric system of governance than from a more centralized system.

Despite the merits of decentralization, public health policies often are executed through bureaucratic institutions in conjunction with various health experts. Koppl (2022) extends the theory of "expert failure" to public health, arguing that an effective check against such failure is provided by competition among policymakers. Koppl centers his argument, not around incentives per se, but around the diversity (or lack thereof) of scientific knowledge, advocacy, and opinion. The narrower the channel of information and feedback between policymakers and experts, the more likely one is to adopt ineffective or destructive policies. Such was the nature of the British Government and the Scientific Advisory Group for Emergencies (SAGE) during

the COVID-19 pandemic. Pennington (2022) advances on similar ground, using Michel Foucault's social constructionism to shine a light on the importance of narratives and discursive formations in the governance of public health. Discursive constructions emerge through prevailing narratives and social beliefs, which enable political authorities and scientific "experts" to mobilize interest groups in pursuit of political aims.

The final two papers explore the role of the state in public health and the potential tradeoff between health and liberty. Koyama (2022) argues that such a tradeoff is present in the short run, whereby government intervention can prevent catastrophes of contagion and infectious disease. In the long run, however, the tradeoff disappears as freer societies become healthier through economic development and scientific advances in medical technology. Koyama rightly recognizes such progress as a genuine challenge to liberal institutions and their apologists—one that must be taken up by serious social scientists going forward. Furton (2022) takes up the challenge, contending that the alleged tradeoff between public health and individual liberty likely is overstated. He argues that political involvement in public health reform tends to occur during health *crises*, wherein policies are passed under conditions of extreme urgency and uncertainty. Reforms made during crisis—where institutions are more malleable—can become embedded, leading to long run, systemic government growth. Subsequent health crises therefore must be met with larger, more cumbersome public health institutions.

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