Our Health Policy Contranyms
By Neil Seeman

Smiles, says the old joke, is the longest word in the English language, since there is a mile between the two s's. Whoever thought this up missed the health policy literature – with its long, deliberately obtuse abstractions.

I have worked as a lawyer (where "submit" means "say") and in the large corporate sector (where a "resource" is a "person"). But in health policy we see the increasing use of contranyms, words that contain opposing meanings. A non-health care example of a contranym is "to buckle," which can mean "to fasten" or "to wobble and break." Contranyms can result from what grammarians call polysemy, where one word morphs into different, and ultimately opposing, meanings.

Consider three leading contranyms in the health policy context. One meaning is the word as originally conceived in the dictionary; the other, opposite meaning, is how it has come to be applied in health policy discussions. In each case, there may be an unstated, but rational, method to this linguistic madness.

1. "Stakeholder" is generally used in the health policy lexicon to mean: "a person or organization with a legitimate interest in a given situation, action or enterprise." Since this definition of "stakeholder" is opposite to the original meaning of the word, "stakeholder" – "a person holding the stakes for others," i.e., a lackey – the word has become a contranym.

If we think about it, all Canadians should be "stakeholders" – equal, and equally legitimate – in all matters of health policy (in fact, our Canada Health Act mandates as much). We use the word "stakeholder" to limit, pragmatically, the numbers of individuals whose views we consider when planning policy: in so doing, do non-stakeholders (i.e., "fringe" players) thereby become lackeys?

2. Next time you're at a policy conference, count how many times you hear the word **iterative**. (Prior to this essay, there were over 100 separate references to the word in Longwoods publications). Its use seems to be growing. "Iterative development" – or common variants, "the next iteration," or "iterative process" – contain a contradiction. "Iterative" means recurring or repetitive, and, yet, "development" or "process" signify advancement. When we use any such phrases, we are unconsciously hedging our bets, insinuating that the "next iteration of the strategy" may veer sideways or even reverse course.

3. To “**invest**” in an initiative, as understood in the private sector, is to expect a financial return, or profit. And yet, in health policy, there are finite government resources. Policy choices require trade-offs, and a failure to consider trade-offs leads us into the trap of the open-ended fallacy, or what economists consider the failure to think clearly about a policy’s knock-on effects. And so, every time you hear the word “invest,” consider whether the “investment” is being used in its purist sense (to realistically expect a return) or whether the “investment” will necessarily cleave (itself a contranym) realizable gains from another policy.

To be sure, the US context offers more colourful context for oxymorons, notably “managed care.” There may be something uniquely Canadian about the health policy contranym: a deliberate obfuscation of what we aim to say. We care about all stakeholders, but sometimes some stakeholders may be more important to us than others; policy forges ahead in iterative stages, since, perhaps, we are too risk averse to embrace the frontier of innovation; and we may talk a good game about investment, but we may be leery of appearing to endorse the language of profit.

This sort of linguistic muddle is a matter of custom. Is the “custom” a byproduct of “conventional behaviour” or “deliberate design”? That’s a conundrum.

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