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Commentary

Is the future of "population/public health" in Canada united or divided? Reflections from within the field

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Introduction

"Are population and public health truly a unified field, or is population health simply attaching itself to public health as a means of gaining credibility?"

This commentary was prompted by the above question, which was asked during K. L.'s PhD candidacy exam. In response, K. L. cited recent developments in the field to support her conviction that population and public health (PPH) existed positively as a unified discipline. However, through conversations that ensued over the subsequent weeks and months, we concluded that this issue goes deeper than the existence of departments and organizations labelled "population and public health," and may benefit from debate and discussion, particularly for the incoming generation of PPH scholars. In this commentary, we argue that (1) the PPH label at times implies a coherence of ideas, values and priorities that may not be present; (2) it is important and timely to work towards a more unified PPH; and (3) both challenges to and opportunities for a more unified PPH exist, which we illustrate using the broad areas of research funding, the public health workforce and PPH ethics.

Argument 1: The PPH label implies a coherence that may not be present

In our experience, the PPH label at times conveys the impression of a coherence of ideas, values and priorities that may not exist. The impression of coherence is conveyed in many ways; for example, by PPH graduate training programs that exist in universities in Calgary,[1] Vancouver,[2] Ottawa[3] and Waterloo;[4] by the existence of PPH departments within health systems;[5,6] and by various historical developments (see Table 1). Yet, the coherence is not always present in practice. K. L., for example, recalls meeting a fellow graduate student at a national public health meeting who remarked that they were used to "no one knowing what [population health] is" and that they "usually just say public health," thus implying that they are—at least to some extent or to some audiences—the same. A contrasting example is L. M.'s experience, as an academic who would describe herself as a "population/public health researcher," of being regarded by colleagues within public health as "not really a public health person" because she does not have a health professional degree. Therefore, the need to clarify the boundaries and future of PPH remains, particularly due to the increasing number of trainees in this field.

Argument 2: It is important and timely to work towards a more unified PPH

A key question at the heart of our commentary is whether PPH *should* be a unified discipline. Some have asserted that the answer is "no."[7] Arguments against a unified PPH include important points such as the concern that PPH is too broad in scope to be useful or that it carries the potential of diluting the urgency of public health.[7]

We disagree, and feel that efforts toward a more unified PPH are both important and timely. These efforts are important because embracing the social determinants of health (SDOH) and thinking critically about health inequities, which PPH aims to do,[8] is necessary to accept a holistic conceptualization of health and to overcome professional and organizational silos that prevent intersectoral action on health and health equity. In some cases, overcoming silos includes offsetting historical changes to the public health system. For example, in many Canadian jurisdictions, "health" presently constitutes its own ministry (e.g. Alberta Health or Health Canada), implying a separation from other determinants of well-being, whereas formerly it was broader in scope (e.g. the federal Department of Pensions and National Health [1928] and Department of National Health and Welfare [1944]).[9,10]

It is timely to work towards a more unified PPH. Unlike even 20 years ago, there are now many programs of study in

Highlights

- Despite the supposed integration of "population and public health" (PPH), issues in the areas of research funding, the public health workforce and ethics continue to present challenges to the field's unity.
- The authors argue that overcoming these challenges is a worthwhile goal for the future of population well-being in Canada.

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Canadian universities for students who do not necessarily intend to go into public health in its conventional sense (e.g. public health nursing or a public health and preventive medicine specialty) but rather who wish to pursue an academic career, or to apply principles of PPH in a range of sectors. The Bachelor of Health Sciences Program at the University of Calgary, and in particular the Health and Society specialization within that program, is an excellent example. We disclose that this relatively recent trend describes us: we were both drawn to the idea of a unified PPH because it represented a way to bring together health and social sciences/humanities in a way that is connected to, but importantly steps outside of, the formal health sector and professions.

Argument 3: Important challenges and opportunities for an integrated field to exist

To permit reflection on PPH, we identify three (of potentially many) areas that appear to create cleavage in the field: research funding, the public health workforce and PPH ethics. For each area, with the intention of opening a dialogue, we identify what we see as key challenges and opportunities.

1. Research funding

Challenge: The 2009 announcement by the Social Sciences and Humanities Research Council of Canada that they would no longer fund health research created a challenge for PPH as an interdisciplinary field, as it left many social scientists working within PPH to navigate the different funding landscape and procedures of the Canadian Institutes of Health Research (CIHR).[11] This change highlighted the different norms and expectations for social sciences versus traditional health research (e.g. structure of research grant applications, authorship, length and pace of publications, emphasis on theory),[12] as well as the areas of research considered viable and worthwhile. These differences, arguably, may particularly disadvantage those who are most poised to contribute rich theoretical and critical scholarship to PPH.

Opportunity: The integration of social and health sciences is essential to PPH. As a national funding agency and guiding body for health research in Canada, CIHR provides a forum where challenges to integration can be overcome. One example is the significant efforts that have been made by CIHR's Institute of Population and Public Health (IPPH) to shift the peer review landscape to facilitate fair and transparent evaluation of interdisciplinary applicants by reviewers with appropriate expertise through specific, priority-driven competitions.[13] Though the challenges noted above have not disappeared, it seems that important progress is being made.

2. Public health workforce

Challenge: To a large extent, the public health workforce (e.g. physicians, public health inspectors, laboratory workers, nurses) remains situated within the health sector (i.e. in health services organizations or ministries of health). This arrangement presents a challenge for action on the SDOH and health equity, which is at the forefront of PPH and by definition goes beyond the regulatory and legal frameworks of public health. Action on the SDOH may fall outside the scope of day-to-day public health work providing services and programs to the public.[14] Additionally, the legislative framework that mandates public health in jurisdictions may not support an integrative PPH. For example, Alberta's *Public Health Act: Revised Statues of Alberta 2000*[15] makes no mention of the SDOH, or even of chronic disease. These issues may present a source of cleavage between the large number of experts working within public health's core functions (e.g. disease prevention, and communicable disease prevention in particular) and the stated aim of PPH to broadly influence population health (i.e. via social policy interventions, outside of the health system).

Opportunity: Despite these sources of cleavage, significant opportunities do exist and in some cases progress has been made within the professional and regulatory arms of public health towards a more unified field. Brassolotto, Raphael and Baldeo,[14] for instance, have documented that in Ontario some health units actively pursue advocacy and action on the SDOH in addition to their delivery of more traditional public health services. Public Health Ontario, for example, has incorporated addressing determinants of health and reducing health inequities throughout the *Ontario Public Health Standards.*[16]

Legislative progress has also been made in some jurisdictions. In British Columbia, the *Public Health Act (SBC 2008)* includes chronic disease as a health impediment, which at least in theory allows for the minister to incorporate the social determinants of health or equity concerns when developing a plan "to identify, prevent and mitigate" its adverse effects.[17] Quebec's *Public Health Act (S-2.2)* goes further, by allowing the minister of health, public health director and institutions to intervene not only to prevent disease and trauma, but also to consider "social problems that have an impact on the health of the population"[18,p.4] through acting on the SDOH. An example of this is Quebec's promotion and implementation of healthy public policies through health impact assessment.[19] Finally, in recent years, the Public Health Agency of Canada has attempted to define the ever-expanding PPH workforce, through core competencies for public health work and the harmonization of information on the diverse postsecondary and postgraduate training opportunities that exist in PPH.[20,21] Such attempts present the opportunity to better understand some of the features of PPH that permit intersectoral action and build on them, toward a more integrative PPH workforce and field of practice.

3. Efforts to advance the ethical foundations of PPH

Challenge: As public health practice is predominantly situated within the health care system, its ethical guidelines have traditionally been sanctioned by bioethical principles (i.e. autonomy, beneficence, nonmaleficence, respect for human rights) and guided by the moral theory of utilitarianism (i.e. the public good).[22] However, as noted elsewhere,[23,24] these bioethics principles have proven inadequate to fully meet the challenges of PPH, where intervention activities include structural interventions that apply to whole populations and may therefore conflict with the will of the public to the benefit of the population (e.g. community water fluoridation). This tension has led to the creation of critical subdisciplines (e.g. public health ethics) to encourage advancements to ethical thinking in ways that respond to this need (e.g. the Nuffield Council on Bioethics' stewardship model).[25]

Opportunity: There is an exciting trend in evolving critical scholarship on some of the unique challenges that exist for population

health interventions sanctioned under public health ethical frameworks. For instance, there is scholarly debate around the merits and drawbacks of population-wide, or universal, interventions in PPH that, on the one hand, identifies potential negative consequences of the population-level approach,[26,27] and, on the other, argues for the leverage and potential equity of that approach.[28] This work will contribute to an increasingly robust intellectual foundation for PPH. Relatedly, some ethical frameworks that better incorporate aspects of population health have emerged that respond to the field's need for transparency and minimal restriction, social justice and equity.[23,29-31] Such work may facilitate greater unification of PPH, as it begins to tackle the issue

TABLE 1
Historical timeline of key events in the development of "population and public health," 1974–2004

Year	Event	Contribution to field of PPH
1974	Lalonde Report[32] published	Influences a number of developments in health promotion
1975	National Health Research and Development Program is established	Stimulates and supports research into national health issues
1978 (UK)	Marmot, Rose, Shipley and Hamilton.[33] publish findings from Whitehall I	Introduces the notion of the social gradient into epidemiological research
1982 (CAN)	Canadian Institute for Advanced Research is established	Serves as a "think tank" for developing new conceptual frameworks
1985 (UK)	Rose publishes *Sick Individuals and Sick Populations*[34]	Introduces the population strategy of prevention
1986 (Intl.)	Ottawa Charter for Health Promotion[35] published	Facilitates developments in health promotion and introduces the prerequisites for health
(CAN)	Epp Report[36] published	Canadian government departments begin to adopt health promotion in their programs
1987 (CAN)	Canadian Institute for Advanced Research establishes a population health program	Reflects changes in government and in PPH; public health is shifting away from health promotion towards population health
1989 (CAN)	Canadian Institute for Advanced Research introduces population health concept	Considers complex interaction of determinants of health
1991 (CAN)	Mustard and Frank[37] publish *The Determinants of Health*	Concludes that major determinants of health lie beyond the reach of the medical care system, at the individual and population levels
1991 (UK)	Marmot, Davey Smith, Stansfeld et al.[38] publish findings from Whitehall II	Brings language of health inequality to the forefront of population-level research
1994 (CAN)	Evans, Barer and Marmor[39] publish *Why are Some People Healthy and Others Not?*	Provides epidemiological support to explain the influence of social and economic factors on health
1994 (CAN)	Federal, provincial, and territorial ministers of health publish *Strategies for Population Health: Investing in the Health of Canadians*[40]	Population health approach is officially endorsed by governments
1996 (CAN)	Hamilton and Bhatti[41] produce Population Health Promotion: An Integrated Framework for Population Health Promotion	Combines ideas of population health and health promotion
1997 (CAN)	Federal, Provincial, and Territorial Advisory Committee on Population Health is formed	Provides government definition of population health
1998 (CAN)	Hayes and Dunn[42] publish systematic review on population health in Canada	Identifies multiple ways that population health can be conceived, as a perspective, research, framework, or approach
1998 (CAN)	Poland, Coburn, Robertson, and Eakin[43] publish *Wealth, Equity and Health Care: A Critique of a "Population Health" Perspective on the Determinants of Health*	Critiques the population health model for being atheoretical and reductionist
2000 (USA)	National Committee on Vital Health and Statistics at the Centers for Disease Control considers Canadian Institute for Advanced Research concept of population health in their vision for health statistics	Exemplifies international spread of the population health concept
2000 (CAN)	Canadian Institutes for Health Research established through an Act of Parliament, replacing the National Health Research and Development Program	Includes the Institute for Population Health in 2000
2001 (CAN)	Health Canada's Health Promotion and Programs Branch produces a position paper for health promotion staff	Population health approach is adopted as a unifying force by Health Canada for its spectrum of health system interventions
2003 (CAN)	Coburn[44] publishes "Population Health in Canada: A Brief Critique"	Acknowledges that health promotion had been "squeezed out" by population health as a credible health policy discourse
2004 (CAN)	Public Health Agency of Canada formed	Adopts a population health approach and establishes regional offices of the Population and Public Health Branch to mobilize it

Abbreviations: CAN, Canada; Intl, international; PPH, population and public health; UK, United Kingdom.

of how to balance the utilitarian aspect of public health, which many view as its key asset, alongside thoughtful consideration of the possible unintended consequences of this approach toward improving health for all.

Conclusion

As PPH continues to evolve throughout the twenty-first century and enrollment in "population and public health" interdisciplinary graduate programs continues to grow, we believe that the question of whether and how to better integrate PPH will remain relevant and important. We recognize that the areas we have considered above (i.e. research, the public health workforce and PPH ethics) are not mutually exclusive and represent only a few examples among many others that likely exist.

We encourage future research and discussion on the topic and we hope that this paper prompts further debate and discussion among PPH leaders, workers and trainees.

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