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SPECIAL SECTION ON WHY PUBLIC HEALTH MATTERS TODAY: COMMENTARY

Why public health matters today more than ever: the convergence of health and social policy

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Abstract

We argue that public health matters more today than ever because it is uniquely positioned as a meeting point or fulcrum between health care and social welfare policy perspectives on the social determinants of health. It combines a grounding in the sciences of biomedicine and epidemiology with the moral imperatives of social advocacy. Health cannot be delivered through health care policy alone and neither can social welfare policy ensure the well-being of all citizens on its own. Social policy is at a disadvantage because it does not engender universal consent the way health policy can. While the way that illness should be addressed is debated, it *should be* addressed to be not contested, as is social welfare for vulnerable populations. The convergence of health and social policy to address the social determinants of health means public health advocacy must explicitly leverage biomedicine to provide materialist and substantive arguments and social welfare to provide the normative and moral arguments. We conclude that a new model of public health advocacy or social lobbying is necessary to effectively raise concerns that health care-focused thinking will not, but with potential heft that social welfare, historically, has not been able to command.

Résumé

Nous affirmons que la santé publique importe plus que jamais puisqu'elle agit comme point de rencontre entre deux perspectives concernant les déterminants sociaux de la santé : celle des politiques de santé et celle du cadre de la politique du bien-être social. La santé publique regroupe une base dans les domaines de la biomédecine et de l'épidémiologie avec les impératifs moraux de la défense d'intérêts sociaux. Une politique sur la santé seule n'est pas en mesure de dispenser des soins de santé, et les politiques du bien-être social, à elles seules, ne peuvent assurer le bien-être de tous citoyens. La politique sociale est défavorisée car elle ne donne pas lieu à un consensus universel de la même façon qu'une politique sur la santé. Alors que nous débattons des stratégies pour aborder les soins de santé, personne ne conteste le fait que *nous devons* adresser ce problème, tout comme le bien-être social des populations vulnérables. La convergence des politiques de santé et politiques sociales pour aborder les déterminants sociaux de la santé exige que la défense de la santé publique exploite la biomédecine afin de fournir des arguments matérialistes et de fond et le bien-être social pour fournir des arguments normatifs et moraux. Nous concluons que la défense de la santé publique et le lobbying nécessitent un nouveau modèle afin de soulever les inquiétudes que la pensée axée sur les systèmes de soins de santé ne réussit pas à atteindre. Ce nouveau modèle aura une pesanteur que le bien-être social, historiquement, n'a pas réussi à inspirer.

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Public health matters more today than ever because its research and practice base is the fulcrum or meeting point between health care and social welfare policy perspectives on the social determinants of health (SDH). Approaches to health care policy in improving individual and population health draw largely upon the sciences of biomedicine and epidemiology, while approaches to social welfare policy are particularly concerned with improving the functioning and well-being of society's most vulnerable. Public health is a midpoint between these orientations as it combines a grounding in the scientific method with the moral imperatives of social advocacy. It is uniquely positioned to link research on health and social outcomes with the moral and ideological arguments that ought to inform policy deliberation and debate in a democratic society. The tension between the approaches is age old, as are efforts to straddle them.

Health sciences build the empirical case for addressing the SDH

Public health has a long track record in research and practice that points to an overarching moral and social responsibility for population health. Conceptualizations of health, however, have had a contested history with interpretations ranging from an individual, biomedical focus to health being the product of the social, economic, and environmental conditions in which people live (Baum 2016). From its earliest manifestations, public health has straddled the two interpretations, as in the work of such scholars as Virchow, Durkheim, Engels, and McKeown.

Conceptualizations of health that favour the SDH tend to support attention on the political economy or how political and economic structures need to be modified in order to improve population health (Raphael 2011). The Commission on Social Determinants of Health (2008) advanced understanding of the SDH and particularly the concept of health equity, that is, that the "unequal distribution of health-damaging experiences is not in any sense a natural phenomenon but is the result of a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics" (p1). Contemporary, public health research has used scientific methods to build empirical arguments that health inequities and the social gradient of health require policy responses (Marmot 2017). This conceptualization, however, has struggled to gain policy headway; Lewis (2004) argues that "a social determinants approach represents a deep structure idea that does not sit easily with the foundational biomedical model of health" and that the existing paradigm frames the idea of "improving health through building social structures as irrelevant, unachievable or ludicrous policy options" (p12–13).

Ideological and partisan positions of elected Canadian legislators have been found to negatively affect receptivity to public health policy agendas (Patterson et al. 2017). This has also been reported in Australia, where interviews conducted by Baum et al. (2013) with former federal health ministers found a range of views on the role of the health sector, including a commitment to action on the SDH, but the research concluded that "underlying ideologies affected the extent to which they championed action addressing health equity through action on the SDH" (p142).

While rhetorical nods to SDH and health equity can be found in political discourse and health policy, specific recommendations on policy options are likely to be evaluated according to traditional ideological priorities. For instance, Patterson et al.'s (2017) study reflected that recommendations to address household food insecurity "will be assessed in terms of how they relate to existing political positions and … legislators will respond on that basis" (p.878). Thus, "facts" alone do not shape policy; decision-makers take heed of compelling narratives and normative arguments. Crammond and Carey (2017) powerfully contend that public health proponents cannot and should not shy away from the normative groundings of their perspective:

> Since political argument is the primary tool to force policy paradigm shifts, the incorporation of social justice into advocacy for SDH is to be welcomed (p369) … Embracing moral and political arguments is therefore essential if advocates for action on the social determinants of health are to successfully gain traction with politicians and non-health departments (p371).

Social welfare provides the normative case for addressing SDH

While health cannot be delivered through health policy alone, neither can social policy ensure the well-being of all citizens on its own. Social policy is at heart a moral enterprise that stems from an openly and avowedly normative stance; its aim is to "improve people's welfare", especially "the welfare of the most vulnerable" (McClelland 2010, p. 3), such as those

living in conditions of poverty. This stance immediately sets social policy apart from the more universal appeal of health policy—while poverty is easily moralized and thus marginalized, anyone might fall ill. Although the way that illness should be addressed is debated, that it *should be* addressed is not contested. In contrast, social welfare policy does not engender such universal consent.

Social welfare policy, its expression by the state and its public support, is based on collectivist values. Thus, successes in building welfare states have been undermined by the ascent of neoliberal values, which have turned social welfare into a "problematic" idea (Bessant et al. 2006). The Global Financial Crisis of 2008, particularly, created a climate that enabled the containment of spending to replace the delivery of welfare as the goal for governments in countries like Australia and Canada (Farnsworth and Irving 2015). As individualism replaces the vestiges of collectivism, we see much of social policy to be catering only to those who cannot support themselves, the most basic responsibility for citizenship expressed by independence from the state and from one's fellows. In the same way that poverty is an ethical issue (Bessant et al. 2006), so is its relief. The debate in social policy is no longer *how* but *whether* poverty should be relieved. Both conservatives and neoliberals argue that the contraction of welfare will encourage financial independence and avoid the "moral hazards" created by the "poverty traps" of income support (Bessant et al. 2006).

The convergence of health and social policy

We consider an example from an earlier era—that of progressivism of the early twentieth century USA—to illuminate our argument. Stivers (2000) writes of the Bureau Men and Settlement Women. The former pursued highly rational, technocratic reform from research bureaus and think tanks while the latter worked directly with the urban poor in inner city neighbourhoods and were driven to action by their outrage over social and economic inequalities. While the Settlement Women's prescriptions were often dismissed, in no small part due to the gendered nature of their work, Stivers (2000) argues that the ultimate success of policy advocacy came in infusing moral direction into decision making and disrupting norms of objective male expertise with a more collectivist and participatory ethos.

We argue that public health is thus a moral imperative as well as a scientific practice. Promoting population health and reducing health inequities are defining issues of our time, and it is public health leaders' ethical and moral responsibility to explicitly advocate for policies that address the distribution of the SDH that produce health inequities (Marmot and Allen 2014). This requires effective public health advocacy that utilizes the unique strengths of each of these public policy fields, that is, draws on the foundations of biomedicine to provide materialist and substantive arguments, and social welfare to ingrain normative and moral arguments. A strong public health voice raises concerns that health care-focused thinking struggles to articulate within the bounds of its accepted discourse, but with potential heft that social welfare, historically, has not been able to command. The task of public health today is to bind together our modern version of these silos. Convergence can begin with partnering with social welfare to "strengthen the explanatory models used in social determinants of health" by "advancing a nuanced appreciation of peoples' lives and the factors that facilitate or enable them to improve their social circumstances and, in turn, their health" (Carey and Crammond 2014, p. 499).

We conclude that public health needs new models and determined collaborative action to address the complexity of requisite systems change. Recommendations from Narberhaus (2014) regarding a new activism for systems change are particularly resonant for public health:

- Articulate perspectives that incorporate multiple issues, sectors, and levels of society to find common framing,
- Continue to develop new ways to challenge the entrenched worldview that is embedded in the very systems that are threatening the public's health, and
- Focus on pragmatism or what is needed (as opposed to what is possible) to "shift the logic of debate".

This type of renewed public health activism is very much in keeping with Demaio and Marshall's (2018) call for public health to embrace social lobbying. This means a "cultural shift that sees public health professionals become comfortable with the idea of assertive advocacy to governments" and cultivate the skills "to navigate the legislative process, communicate across social-political divides, and influence policy makers" (p1559). Now is the time to engage and support this new generation of public health social lobbyists.

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