Shifting discourses on health in Canada: from health promotion to population health

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SUMMARY
This paper argues that discourses on health are products of the particular social, economic and political context within which they are produced. In the early 1980s, the discourse on health in Canada shifted from a post-Lalonde Report lifestyle behaviour discourse to one shaped by the discourse on the 'social determinants of health'. In Canada, we are currently witnessing the emergence of another discourse on health—'population health'—as a guiding framework for health policy and practice. Grounded in a critical social science perspective on health and health promotion, this paper critiques the population health discourse in terms of its underlying epistemological assumptions and the theoretical and political implications which follow. Does it matter whether we talk about 'heterogeneities in health' or 'inequities in health'? This paper argues that it does, and concludes that population health is becoming a prevailing discourse on health at this particular historical time in Canada because it provides powerful rhetoric for the retreat of the welfare state. This paper argues further that it is health promotion's alignment with the moral economy of the welfare state that makes it a counter-vailing discourse on health and its determinants.

Key words: health discourses; health promotion; population health

INTRODUCTION
Discourses on health come into and go out of fashion, but not arbitrarily. Rather, they emerge and gain widespread acceptance primarily because they are more or less congruent with the prevailing social, political and economic context within which they are produced, maintained and reproduced. In addition, because they are always attached to other interests and agendas—professional, economic, political, cultural, ideological—the ways in which we conceptualize and speak about health are never just about health; they also function as repositories and mirrors of our ideas and beliefs about human nature and the nature of reality, as well as about the kind of society we can imagine creating and how best to achieve it. Examining particular discourses on health, therefore, provides a unique window onto these deeper ideas and beliefs.

Discourses on health include the ideas we have about, and the explanations we offer for, what health is and what determines it, as well as the particular practices that are produced by these ideas. Biomedicine represents the most successful discourse on health, at least in the Western industrialized world. Characterized by scientific medicine with its principles of the specific etiology and nosology of diseases, particular clinical diagnostic and treatment protocols, all in the context of the individual physician–patient relationship, biomedicine has functioned as the dominant discourse on health in Canada, as elsewhere, for most of this century (Lock and Gordon, 1988). In the last few decades, a counter-vailing discourse on health has emerged in the public health arena. Variously called 'the new health promotion' or 'the new public health'.
this alternative discourse has been characterized by a broad socio-environmental conceptualization of health, a recognition of the social determinants of health, and a call for broad-based changes in the social and economic environment in order to improve health (Robertson and Minkler, 1994).

Recently, another discourse on health has emerged in Canada. In the last 5–6 years, ‘population health’ has become the new ‘buzz-term’ in health policy circles at both provincial and federal levels, reflected, in some cases, in a change in name of certain government branches and departments. Likewise, the term is finding its way into the health research domain by being incorporated into the language and guiding principles of recent requests for proposals issued by major health research funding agencies in Canada. This paper critically examines the shift from health promotion to population health as a guiding discourse for public health policy and practice in Canada. It argues that this shift is occurring in the context of an increasingly pervasive public discourse on ‘fiscal crisis’ which, in turn, provides much of the rhetoric for the current dismantling of the welfare state in Canada.

The first part of this paper discusses briefly the historical background for this shift in the discourse on health, outlining the central features of both the new health promotion and population health. It should be noted here that, while neither the new health promotion nor population health exist and function as homogeneous discourses, for the purposes of this discussion they will be examined as ideal types. The fundamental differences between the new health promotion and population health are explicated and, finally, the policy implications of the shift from health promotion to population health as a guiding framework for health policy in Canada are discussed.

HEALTH DISCOURSES IN CANADA

Part 1: from lifestyle to social determinants

In the immediate post-World-War-II period in Canada—a period of intense nation-building—the discourse on health was very much tied up with the issues of accessibility to health care. The provision of universal access to health care has been regarded as a cornerstone of the Canadian welfare state, and its final implementation in 1967 strategically coincided with the Centennial celebration of Canadian Confederation. However, no sooner had the last piece of Canadian medicare been legislated into existence, than the federal government established a task force to examine the costs of this new universal and comprehensive health care financing program. Shortly after this task force reported its findings (Health and Welfare Canada, 1969), Health and Welfare Canada published a key health policy document, A New Perspective on the Health of Canadians, otherwise known as The Lalonde Report (Health and Welfare Canada, 1974).

The discourse on health articulated in the Lalonde Report provided a guiding framework for health policy, both nationally and internationally; for example, the principles it laid out were incorporated into the 1980 US Surgeon General’s report (US Surgeon General, 1979). The Lalonde Report introduced the ‘Health Field’ concept, an explanatory model of the various factors which determine health. The main argument of this concept was that access to health care was not the only—and, perhaps, not even the most important—determinant of health, the other determinants being lifestyle, human biology and the environment. The lifestyle component of the Health Field came to dominate health discourse in Canada, and elsewhere, during the 1970s and early 1980s, institutionalized in health policy and manifested in public health program planning which emphasized individual-level behaviour change as the most effective strategy for improving health (O’Neill and Pederson, 1994).

Many critiques have been written of the lifestyle approach to explaining and improving health (Labonte and Penfold, 1981; Hancock, 1986; Minkler, 1989). Briefly, the primary thrust of these critiques was that the lifestyle approach, by neglecting to consider the social, economic and political context within which individual health behaviours are both formed and occur, essentially ends up ‘blaming the victim’ (Ryan, 1976; Labonte and Penfold, 1981). As a result of these critiques, and also as a result of the growing awareness that access to health care had not significantly reduced the inequalities in health between the richest and the poorest in Canada (Manga, 1987), an alternative discourse on health promotion began to emerge in the mid-1980s.

Premised on the notion of the ‘social determinants of health’, and informed by World Health Organization (WHO) discussion papers (WHO,
Part 2: from social determinants to determinants

In 1991, Canadian health economists Robert Evans and Greg Stoddart published a highly influential paper in Social Science and Medicine (Evans and Stoddart, 1990). Entitled ‘Producing health, consuming health care’, this paper laid out what were to become the central features of a newly emerging discourse on health, namely, population health. This paper was followed in quick succession by two more influential publications: a 1994 book entitled Why are Some People Healthy and Others Not? (Evans et al., 1994a); and the entire fall 1994 issue of Daedalus, The Journal of the American Academy of Arts and Sciences, entitled ‘Health and Wealth’ (Daedalus, 1994). The key features of the population health approach are briefly outlined as follows.

Like the earlier Lalonde Report, the advocates of population health make the central claim that health care is not the most important determinant of health, grounding their arguments in what has come to be known as ‘the McKeown thesis’, namely, that medical care had little to do with the improvements in life expectancy (a commonly used aggregate measure, along with infant mortality, of the health status of a nation) observed in the UK at the end of the last century (McKeown, 1979). They also invoke the often-observed relationship between overall health, again measured as life expectancy, and economic growth as measured by gross national product (GNP), observed in both developed and developing nations (Wilkinson, 1990, 1992). In spite of later analyses by Wilkinson (1993, 1994), indicating that those countries with the smallest income gap between the richest and the poorest (as measured by the Gini coefficient) have experienced the biggest improvements in overall life expectancy, the proponents of population health, explicitly adapting the ‘Health Force Field’ of the Lalonde Report, offer a complex model for the explanation of health, in which everything appears to cause everything else. In this model, equal weight is given to all putative ‘causes’ of ill health, and economic inequities are neutralized and reduced to a single causal box called ‘prosperity’. Clearly missing in the model is any reference to the social, political and economic context within which these ‘causes’ are produced (Coburn et al., 1996; Poland et al., forthcoming).

With their emphasis on epidemiological explanations of health (Hertzman et al., 1994) and the promises offered by genetic research (Baird,
population health advocates reveal their commitment to and faith in an ultimately biological explanation of health (Evans et al., 1994b). In addition, their major recommendation for improving health status is to take money out of the health care sector and divert it to the more ‘wealth producing’ sectors of the economy in order to increase the GNP, the argument being that more wealth overall will result in more health overall. Population health thus reveals itself as not so much a new discourse on health as a return to a reductionist epidemiological explanation of health (Labonte, 1995), but now wedded to economic thinking. Indeed, the key formulators of this new discourse on health are all members of the Canadian Institute for Advanced Research (CIAR)—an élite international group of, primarily, health economists and epidemiologists, with a smattering of social scientists and little representation from either the health promotion or public health fields.

Population health and health promotion, as the currently competing discourses on health in Canada, appear to have much in common: both argue for an explanation of health beyond the strictly biomedical; both argue for a shift of resources away from ‘high-tech’, acute, hospital, physician-based care; both argue for the key role of income and economic well-being as determinants of health. However, health promotion and population health differ in several significant ways. One of the underlying principles of population health, often expressed by its proponents, is the notion that, with respect to explanations of differences in health status and what can be done about them, ‘theory divides, data unite’ (Evans, 1995); that is, theory can be dispensed with because the data, or the ‘facts’, will provide both the explanations as well as strategic directions for remedial action. As will be shown below, this notion declares the foundations of population health in what Guba (1990) characterizes as the epistemological assumptions of positivism. These assumptions, and what they reveal about the theoretical underpinnings and political implications of population health—and how these differ from the underlying principles of health promotion—are the subject of the remainder of this paper. By explicating the fundamental differences between these two discourses on health, this paper also attempts to show how a health promotion approach gives a better account of health and the kinds of social actions we need to take in order to improve it, than does a population health approach.

Just as with health promotion, the term ‘population health’ has been used to refer to a diverse range of explanations of and strategies for improving the health of populations. For the purposes of this paper, population health refers to that discourse on health specifically advanced in the writings of the CIAR.

**EPISTEMOLOGICAL ASSUMPTIONS OF POPULATION HEALTH AND HEALTH PROMOTION**

Before considering the theoretical and political implications of population health, it is useful to examine more closely the positivist epistemological assumptions underlying this discourse, as revealed in the notion that ‘theory divides, data unite’, and to compare these with the assumptions underlying health promotion.

**Nature speaks**

The notion that ‘data unite’ is founded on the epistemological assumption that ‘Nature Speaks’—that is, that social phenomena exist ‘out there’ in the world, simply awaiting the right methodological tools in order to be ‘discovered’. This epistemological position—characteristic of a positivist stance with respect to the nature of knowledge—ignores the extent to which, according to an alternative epistemological view, social phenomena are socially constructed and that, therefore, the data with which we represent them are second-order social constructions (Lincoln and Guba, 1985; Guba, 1990).

How is it that data can be considered to be socially constructed? Firstly, what counts as data depends on what we judge to be important to notice in the first place, and then to measure. As historian of science Thomas Kuhn (1970, p. 7) says, ‘the commitments that govern normal science specify not only what sorts of entities the universe does contain, but also, by implication, those it does not’. Indeed, the very methodological tools we use for gathering and analysing data—the survey, the in-depth interview, the logistic regression equation, participant observation—themselves carry ontological and epistemological assumptions, predicated, first, on what we think exists ‘out there’ to be discovered and, second, on what phenomena we choose to isolate and legitimate as data. Again, as Kuhn argues:
In short, consciously or not, the decision to employ a particular piece of apparatus and to use it in a particular way carries an assumption that only certain sorts of circumstances will arise. (Kuhn, 1970, p. 59)

The second way in which data can be regarded as socially constructed has to do with the nature of what it is that typically constitutes data, namely ‘variables’. But what is a variable? In her article on ‘The tenacious assumptions of biomedicine’, medical anthropologist Deborah Gordon offers the following definition:

It is an aspect of the situation that can be lifted out of its context and altered without affecting that context. In other words, underlying the notion of a variable is a vision of the universe as a collection . . . of relatively discrete and encapsulated items. (Gordon, 1988, p. 26)

The idea that aspects of a situation not only can be but should be decontextualized and still have any meaning seems problematic (Nord, 1989). We use variables to generate statistics which, we claim, tell us something about the world we live in and who we are in it. With its emphasis on aggregate data, it is difficult to find, in any of the writings on population health, actual persons in the context of their particular concrete daily lives.

On the other hand, with its emphasis on a broad conceptualization of health and on person-centred (Edwards, 1996; Raeburn and Rootman, 1997) and community-based definitions of health issues (Labonte and Robertson, 1996), health promotion makes room for the stories which individuals and communities tell about their everyday experiences of health, and legitimizes them as being as important to our understanding of health as statistics on morbidity and mortality rates. In other words, health promotion attempts to put the human faces back on the statistics, thereby recontextualizing the ‘variables’ which had been removed from their original context.

Data are superior to theory

Another epistemological position revealed in the statement of ‘theory divides, data unite’ is that somehow data are superior to theory. This appears to be based on two underlying assumptions: (i) that unity is preferable to diversity; and (ii) that theory is ideological in a way that data are not.

Unity is preferable to diversity

Underlying this view is the assumption that the different or even contradictory explanations, which may result from diversity, can and should be eliminated; and that order and consistency—as features of unity—are the ‘normal’ state of things, or at the very least desirable and achievable. The goal of research is to find the right tools to get the ‘facts’ right so that we can all agree on what the problem is and how it should be solved. Not only is there a ‘real’ Nature to speak, but she speaks in a univocal way.

Health promotion, on the other hand, acknowledges diversity and does not seek such consensus (Labonte and Robertson, 1996). Rather, it recognizes that there are multiple discourses on health and that the accounts we give of health depend on where we are located in the broader social, political and economic context (Eakin et al., 1996). Indeed, with its emphasis on a broad conceptualization of health and with its explicit commitment to empowerment, community-based health planning and participatory action research, health promotion focuses on opening up space for those whose voices are often ignored or left out, namely, the voices of people living their daily lives in particular locations in the broader social, political and economic context, locations that have particular consequences for their health (Labonte and Robertson, 1996).

Theory as ideological

It would appear that the most damning charge that can be leveled at any scientific observation or argument is that it is ‘ideological’. What this tends to mean is that it is not objective, not neutral and, therefore, is ‘contaminated’—at best, with the investigators’ theoretical and methodological biases, at worst, with politics.

The assumption about the ideological nature of theory and the non-ideological nature of data is based on an even deeper assumption—that theory and data can be separated. However, as many have argued, the criteria with which scientists go into the world in order to investigate it by gathering data are already theory-laden (Kuhn, 1970; Lincoln and Guba, 1985; Guba, 1990; Longino, 1990). This is not to say that there is no world ‘out there’ which we can know, but rather that we encounter the world ‘out there’ in terms of the multiple worlds ‘in here’. As philosopher of science, Helen Longino, says:

Our experience is a product of the interaction of our senses, our conceptual apparatus, and . . . what aspects of ‘the world out there’ we choose or are directed by intellectual or other commitments to interact with. There
is always much more going on about us than we are aware of, not just because some of it is beyond our sensory thresholds or behind our backs but because in giving coherence to our experience we by necessity select out some facts and ignore others. (Longino, 1990, p. 221; emphasis added)

In other words, Nature may speak but what she says is always interpreted by human beings making certain choices based on certain preferences—ideological, political, philosophical, professional, etc. Research represents one kind of interpretive activity, albeit more systematic than other forms of inquiry, but rarely, as researchers, do we make explicit which ‘commitments’, as Longino calls them, are being given preference in our acts of interpretation.

A health promotion approach, based on a critical social science perspective (Eakin et al., 1996), attempts to be explicit about its epistemological commitments. By aligning itself with naturalistic inquiry (Lincoln and Guba, 1985; Guba, 1990; Labonte and Robertson, 1996), health promotion makes a commitment to a reflexive stance on the part of the researcher. As a paradigm of inquiry, naturalistic inquiry starts from the premise that, as researchers, we do not occupy some privileged position outside of the social reality we study, but rather that our beliefs and values about the world, and who we are in it, influence our inquiries about the world, and consequently determine what we can say about it and ourselves.

In contrast, behind the notion that ‘data unite’ is an assumption that scientific inquiry not only should be, but can be, neutral and autonomous. From this position, knowledge ‘is supposed to be stripped of value and present only facts. Truth tells us how things work ‘naturally’, not ideologically’ (Gordon, 1988). Yet, it would appear that the most powerfully ideological practices are those which claim that their facts are non-ideological because they are scientific (Navarro, 1980). The point then, with a slight twist on Tesh’s (1990) argument, is not to get the ideology out of science but to get the ideology out of hiding.

In order to disclose its hidden ideology, this paper now considers the theoretical underpinnings of population health.

**UNDERLYING THEORETICAL ASSUMPTIONS OF POPULATION HEALTH AND HEALTH PROMOTION**

As a result of its underlying epistemological assumptions, revealed in the notion that ‘theory divides, data unite’, population health is, on the surface at least, atheoretical. Grounded in an apparently theoretically neutral epidemiological account of health based on population-level morbidity and mortality rates, population health does not appear to be based on any theory of society and social change. This seems consistent with the thinly veiled contempt of theory revealed in the notion ‘theory divides, data unite’.

However, if we probe a little deeper into the theoretical foundations of population health what we find is an implicit theory that social change is brought about by adjustments in the economy. One of the recommendations of the proponents of a population health discourse is to shift resources out of the health care sector and into the productive sector, the argument being that the greater wealth which will be produced will produce more health for everyone; this appears to be a version of the ‘trickle-down’ theory of market-based capitalism as espoused by conservative economic thinking which currently prevails. What is left out of this implicit theoretical position is any consideration of how capitalism—and the power, privilege and structural inequity associated with this particular mode of production—has direct effects on health (Navarro, 1976; Laurell, 1989; Navarro, 1990). In other words, we are left holding the proverbial theoretical black box.

With the concept of ‘social determinants of health’, health promotion, on the other hand, takes an explicit theoretical position with respect to what it is that makes some people healthy and others not: namely, that systematic and systemic social and economic inequities (in terms of access to a range of social and economic resources such as money and power and esteem) are major factors affecting the health of individuals and certain social groups. For example, research demonstrating the income gradient for all major diseases indicates not only that the poor get more diseases than those of us who are better off, but also that when they get them they are sicker, and they have poorer health outcomes in terms of long-term morbidity or mortality (see the entire 20 April 1996 issue of the *British Medical Journal*); in other words, poverty is a major risk factor.
for poor health. Research on hypertension amongst African-American males (Klag et al., 1991) and on the relative low-birth-weight rates of African-American babies irrespective of maternal socio-economic status (Wise and Pursley, 1992), indicates that it is not race but rather racism that is and continues to be, a major risk factor for poorer health status of African-Americans. Research like this tells us that there is something about our current social, political and economic arrangements which is bad for people’s health.

Proponents of population health might justifiably counter with the argument that ‘social determinants of health’ is as much a theoretical black box as the ‘trickle-down’ theory of greater wealth production. It behooves those of us who have a commitment to the social determinants of health explanation of health to take up this challenge, to begin to unpack our own black box and to propose theoretical frameworks which might account for the dialectical relationships which we claim exist between health and social phenomena, such as poverty and racism. Research on the relationship between control and health (Rodin, 1986; Syme, 1986) begins to suggest how it is that social facts may become biological facts.

POLITICAL IMPLICATIONS OF POPULATION HEALTH AND HEALTH PROMOTION

What is politically problematic about population health is a consequence of its epistemological and theoretical limitations. Why this desire for the unity which, it is assumed, data will deliver? What is it that inclines us to privilege unity and closure over difference and openness? I would argue that the answers are linked to what political scientist Deborah Stone (1988) calls the ‘rationality project’. If the problem of human needs can be framed as a technical problem based on objective scientific knowledge, then we can avoid the ‘messiness’ of politics. And, I would add, we can avoid the even more dreaded messiness of moral reasoning. Inherent in the notion that ‘theory divides, data unite’ is the assumption that knowledge and its production are separate from politics or morality.

We know—and have known since the middle of the last century (Szreter, 1988)—that it is the poorest amongst us who are the sickest; shouldn’t this tell us something? We also know that it is not the absolute levels of wealth which determine a country’s overall level of healthfulness (at least, as indicated by life expectancy); rather, it is the relative levels of wealth, that is, the gap between the richest and the poorest which is significant—the bigger the gap, the lower the overall life expectancy (Wilkinson, 1994). In other words, economic inequities are bad for everybody’s health, rich and poor. We also know that the countries with the highest GNPs do not necessarily have the smallest wealth gap between rich and poor (Wilkinson, 1994). Doesn’t this tell us something more? Would this not seem to be an argument for changing the way in which we redistribute wealth—existing wealth, that is—rather than simply producing more of it in the context of current redistributive mechanisms? This has less to do with economics and wealth, or even science, and more to do with social values and political will. Ironically, even though much of the data linking overall health status to overall economic well-being are provided by population health advocates, with the exception of more recent work by Wilkinson (1996) little of this kind of political reasoning appears in the writings on population health.

In contrast, health promotion, based on the social determinants of health, is explicitly political. Proponents of health promotion concur with the population health analysis that health care does not necessarily produce health. However, with its emphasis on structural inequities, health promotion argues for a very different social agenda for improving health than does population health. A health promotion approach calls for a reallocation of resources towards other sectors which affect health—such as housing and employment. Health promotion strategies—a significant component of which is ‘healthy public policy’ (Milio, 1981)—also include such broad policy measures as local economic development and the amendment of taxation policy to effect more equitable income distribution (Labonte, 1986).

It has become fashionable, ever since publication of Thomas McKeown’s (1979) momentous book, The Role of Medicine, to minimize the contribution of health care to the improvement in the health of the population. However, Simon Szreter (1988), a history of medicine scholar at Cambridge, reminds us that it was not simply Adam Smith’s ‘invisible hand’ of wealth that provided the key to health improvements. They were, to a great extent, the result of the constellation of a number of factors, including: improved
sanitation, nutrition, living and working conditions, and family planning. And, as Szreter demonstrates, these did not occur ‘naturally’, but rather as the result of the efforts of a coalition of public health reformers, labour activists, and others working from reformist social and political agendas. These are the historical roots of the current health promotion movement which, unlike population health, is not only explicitly political but also explicitly normative (Robertson, forthcoming). This is not to deny, however, the usefulness of systematic scientific inquiry of diverse kinds to illuminate the political and normative stands to be taken.

**An underlying moral economy of health promotion**

This paper concludes with a discussion of the normative aspect of health promotion. Because of its commitment to a social justice agenda (Labonte, 1986; Minkler, 1989; Robertson, forthcoming), health promotion is aligned with the underlying moral economy of the welfare state.

The moral issue at the heart of the modern welfare society is: when does need give people the right to make a claim against the collective? Any given society’s answer to this question is embodied in its ‘moral economy’. Political scientist Deborah Stone (1984, p. 19) characterizes the concept of moral economy thus:

> The moral economy of a society is its set of beliefs about what constitutes just exchange: not only about how economic exchange is to be conducted in normal times but also . . . when poor individuals are entitled to social aid, when better-off people are obligated to provide aid, and what kinds of claims anyone—landowners, employer, governments—can legitimately make on the surplus product of anyone else.

Moral economy is, therefore, grounded in ‘the collectively shared basic moral assumptions constituting a system of reciprocal relations’ (Kohli, 1991, p. 275). E. P. Thompson (1966) originally introduced the term ‘moral economy’ to refer to the principles of fairness and custom which formed the moral underpinnings of the late eighteenth/early nineteenth century food riots that occurred in England in reaction to increases in the cost of bread. Despite the unease with which many political economists consider the notion of ‘moral economy’, Kohli (1991, p. 274) argues that speaking of moral economy shifts the emphasis from individual motivations . . . to the system of reciprocal relations . . . [and] allows us to extend the argument beyond the political and economic sphere in a narrow sense . . . squarely into an analysis of the moral structure of the economy and polity themselves.

Recent discussions about the concept of ‘social capital’ also invoke moral economy notions of reciprocity. Social capital ‘refers to features of social organization, such as networks, norms, and trust, that facilitate coordination and cooperation for mutual benefit’ (Putnam, 1993, pp. 35–36). In a recent analysis of the effects of regionalization in Italy during the 1970s, it was argued that the prosperous communities in north-central Italy, which have a long history of civic involvement and social solidarity, did not become civic because they were rich; rather, ‘the historical record suggests . . . [that] they became rich because they were civic’ (Putnam, 1993, p. 37). The important thing about social capital is that, as a public good and unlike physical capital, it increases with use; additionally, ‘a society that relies on generalized reciprocity is more efficient than a distrustful one . . . [for] trust lubricates social life’ (Putnam, 1993, p. 37). It is interesting to note that both the Jakarta Declaration and the UK Charter for Health Promotion invoke this notion of ‘social capital’. Political scientist Michael Walzer emphasizes this essential relationship between a generalized reciprocity and the life of the community when he says that societies and communities come together, in part, around the communal provision of needs:

> Political community for the sake of provision, provision for the sake of community: the process works both ways and that is perhaps its crucial feature. (Walzer, 1983, p. 64)

It could be argued that any society or community is essentially characterized by the kinds of needs it recognizes and collectively provides for, and the extent to which it provides for those needs. Stone (1988, p. 82) argues that ‘communal provision . . . may be the most important force holding communities together’. In a similar spirit, and in opposition to the prevailing economic view of human behaviour, historian Michael Ignatieff says:

> It is as common for us to need things on behalf of others, to need good schools for the sake of our children, safe streets for the sake of our neighbours, decent old people’s homes for the strangers at our door, as it is for us to need them for ourselves. The deepest motivational springs of political involvement are
to be located in this human capacity to feel needs for others. (Ignatieff, 1984, p. 17; emphasis added)

For a relatively recent challenge to the neo-classical economics view of ‘economic man’ as a rational actor who makes individual rational choices in the marketplace of goods and services on the basis of endogenous preferences, see A Quiet Revolution in Welfare Economics (Hahnel and Albert, 1990).

The welfare state of many late-20th-century Western nations, including Canada, represents an institutionalized mechanism for communal provision. One of the fundamental principles underlying the moral economy of the welfare state is the principle of universality. Richard Titmuss, the late social policy analyst and defender of the British welfare state, has provided some of the most eloquent moral economy arguments for the principle of universality:

The emphasis today on ‘welfare’ and the ‘benefits of welfare’ often tends to obscure the fundamental fact that for many consumers the services are not essentially benefits or increments to welfare at all; they represent partial compensation for disservices, for social costs and social insecurities which are the product of a rapidly changing industrial-urban society. They are part of the price we pay to some people for bearing part of the cost of other people’s progress. (Titmuss, 1968, p. 119; emphasis added)

Titmuss believed in a ‘social theory of causal-ity’ of misfortune, that the disadvantaged are ‘the social pathologies of other people’s progress’ (Titmuss, 1968, p. 134), capturing this thinking in the concept of ‘diswelfare’. Titmuss defends the welfare state on the basis of its integrative function and the positive effects on community solidarity (Reisman, 1977, p. 69), and argues for universal ‘social institutions that foster integration and discourage alienation’ (Titmuss, 1968, p. 133). Ignatief (1984, p. 141), too, acknowledges the moral underpinnings of the welfare state when he says, ‘the moral relations that exist between my income and the needs of strangers at my door pass through the arteries of the state’. In other words, institutionalized redistribution, in the form of the welfare state, acknowledges in a profound way the moral basis of society.

With its emphasis on the relationship between ill health and structurally based social and economic inequities, and on strategies such as empowerment, community development and healthy public policy, health promotion demonstrates its alignment with the underlying moral economy of the welfare state (Robertson, forthcoming). It is in this sense that this paper argues that health promotion gives a better account of health and the kinds of social actions which are necessary to assure and improve it than does population health.

As indicated earlier, with a few exceptions (Wilkinson, 1994, 1996), population health lacks an explicit normative component. Producing more wealth overall—a central health strategy of population health—may not necessarily improve the health of the most vulnerable amongst us or, indeed, the general level of healthfulness—unless attention is paid explicitly to the question ‘cui bono?’, that is, ‘who benefits?’. This necessitates a consideration of the net distributive effect of this greater wealth generation, a fundamentally moral question, and one which is rarely considered in the cost–benefit analyses which now function as the anemic substitutes for political and moral reasoning.

CONCLUSION

There is an increasing body of evidence that it is wealth and social inequalities which create health inequalities (see, for example, British Medical Journal, 312, 20 April 1996). But as a recent article puts it: ‘the growing gap between rich and poor has not been ordained by extraterrestrial beings. It has been created by the policies of governments’ (Montague, 1996). In these days of widespread fiscal conservatism, based on the rhetoric of ‘fiscal crisis’, it should be no surprise that population health appears to have gained considerable currency at all levels of government in Canada. Unintended as it may be, population health provides powerful justification for major cutbacks in health care, the Canadian version of health care ‘reform’. Taking resources out of the health care sector is precisely what politicians with neo-liberal fiscal and social agendas want to hear. But we have no guarantee that, in these mean-spirited times, these resources will be reallocated in any other way which will improve the lives and health of the most disadvantaged amongst us. Seemingly paradoxically, those of us who are committed to a health promotion approach, based on the social determinants of health, may find ourselves arguing against cuts in funding for health care. The removal of resources from the health care sector, advocated by the proponents of population health, can only penalize further those whose
health is already compromised by underlying structural inequities. And, if, as a society, we are not prepared to do anything about those underlying structural inequities, then ensuring equitable access to health care, at the very least, represents an acknowledgement that these inequities do exist. Universal publicly funded access to health care stands as a powerful political symbol of our commitment to the moral economy of collective provision which lies at the heart of what it means to be a community.

A fundamental conviction of this paper is that words and ideas—and the discourses which convey them—matter. Words matter because ‘what we cannot imagine and express in language has little chance of becoming a sociological reality’ (Bellah et al., 1991, p. 15) and because ‘the way we name things and discuss them shapes our feelings, judgments, choices, and actions, including political actions’ (Glendon, 1991, p. 11). Ideas matter because ‘our strongest bulwark against demagoguery is the habit of critical discussion about and self-conscious awareness of the public ideas that envelop us’ (Reich, 1988, p. 10). The language and ideas of the market, corporatism and globalization currently pervade public discourse and provide the rationale for the current and near-universal rapid retreat of the welfare state. As an explanation of health with particular political and economic implications, population health provides additional fuel to these prevailing public ideas. Health promotion offers the possibility of a countervailing discourse (Baum and Sanders, 1995; Robertson, forthcoming).

It matters that we speak of ‘inequities in health’ as health promotion does, thereby pointing to the underlying structural causes of poor health, rather than speaking, as population health does, of ‘heterogeneities in health’, a term with a thin veneer of political neutrality. Heterogeneities in health are an interesting topic of scientific investigation; inequities in health demand redress.

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