Revisiting our Social Justice Roots in Population Health Intervention Research

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Public health has its roots in social justice. Descriptions of public health work in the early 20th century reveal the appalling living conditions of the poor and the inequities that were predominant at the time. Class distinctions were apparent in life expectancy, and in differential rates of access to sanitation, clean water, education, food and adequate housing. Although there have been many improvements in the overall health of Canadians during the past century, substantial inequities remain. Canadian and international reports^{1,2} have implored us to take action on these inequities. In this knowledge age, when we are working to build population health interventions on a solid foundation of theory and rigorous methods, it is important to revisit the social justice roots of population health interventions and consider why, as practitioners and scientists, we have sometimes deviated from these values.

Historical accounts indicate several important eras for population health interventions in Canada. The early part of the 20th century was a period when many basic public health regulations were being put into place to improve sanitation, safely preserve food, and reduce communicable disease transmission.³ Community health workers, who were primarily nurses, were particularly active in school settings and in conducting home visits in poor and underserved communities.^{3,4} Efforts to address deplorable social living and working conditions among vulnerable populations are prominent in descriptions of these early public health programs. Early descriptive epidemiological studies documented important socio-economic differences in health status, but did not consistently interrogate underlying issues of class and power.

Post World War II marked the beginning of an information era. Health education efforts were reinforced with the production of communication materials that could reach all Canadians.⁵ Lt. Col. Gilchrist described how the Department of National Health and Welfare supported the production of resources relevant to child care, venereal diseases, water- and food-borne diseases, and mental health.⁵ Posters, films, books and radio were identified as important delivery methods. Gilchrist noted that health educators working with government services and with voluntary agencies were “unanimous in their opinion regarding the teaching value of the motion picture”.^{5, p. 1416} The technology of the time was an important driver of these public health interventions, providing new modalities to make health information widely accessible and spurring research in the field of health education.

Over the next few decades, behavioural interventions began to gain favour. Behaviour change was viewed as being mainly under the control of the individual and changes in knowledge and attitudes were thought to be primary influences on lifestyle choices. Explanatory theories, particularly from psychology, gained a strong foothold in the field of designing and evaluating public health interventions. However, as Larry Green stated in a 1984 article, “the dominant contributions to the literature on interventions in health

have been, perhaps regrettably, from psychology.”^{6, p. 215} Citing several large-scale community interventions including the Stanford heart health studies, which did not produce the expected health outcomes, Green observed that these interventions had focused on patient education rather than on the broader set of conditions that influence behaviour. Although these studies made many important contributions to our understanding of behaviour change processes, they left questions about other levers and supports for health changes largely unanswered. The prominence of reductionist science provided a set of methods that was a good match for research questions examining the effectiveness of behavioural interventions. Thus, these dominant paradigms in public health science and practice were mutually reinforcing and marked a period when social justice concerns were largely eclipsed by the promise of both quantitative science and individually-oriented interventions.

But there was growing concern that health education and behaviourally-oriented interventions were failing to reach those most in need. James Mason, for example, when he was Director of the Centers for Disease Control remarked, “It is my observation that, up until now, most of the behavior changes we have promoted have involved the better-educated, upper-, and middle-class segments of our society. If health promotion is a good thing, it should be good for the whole society, not just that portion which is favorably predisposed.”⁷ In response to these types of concerns, health promotion efforts began to shift attention towards environmental and policy conditions that shaped individual action, while also considering the mechanisms for collective change processes. The Ottawa Charter for Health Promotion⁸ acknowledged the importance of working at all system levels and across sectors to improve health and to reach vulnerable populations.⁹ It signaled the inherent complexity of public health issues and suggested that scientists needed to bridge quantitative and qualitative paradigms. Fusions of scientific fields, such as social epidemiology, and of research paradigms, such as mixed methods designs, were extending the nature of inquiry about determinants and interventions in public health. With increasing recognition that levers for population health improvements include those targeting macrosocial determinants of health; and that both top-down and bottom-up approaches are needed to reduce inequities through the “nutcracker” effect,¹⁰ population health interventions began to shift, reconnecting us to the social justice roots of public health.

The often-cited example of tobacco control illustrates radical changes in thinking about the design and evaluation of population health interventions that have occurred over the last fifty years. There has been a steady progression in the scientific agenda from one that focuses on tobacco as a lifestyle choice requiring knowl-

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edge and behaviour change interventions, to one that acknowledges tobacco control approaches as examples of complex interventions operating within complex adaptive systems.¹¹ This progression has required an amalgam of the best know-how of many disciplines; and recognition of the longevity, coherence and multi-level nature of efforts that are required to produce and track significant improvements in health at the population level. Consequently, researchers have been led into new domains of inquiry, including the examination of naturally occurring interventions such as policy change processes; comparative studies of social norms and their influence on smokers and policy-makers; and research on interventions that cross jurisdictions and operate at various systems levels. The social justice underpinnings of tobacco control efforts have also been brought into focus. We have seen, for example, how slumping profits in higher-income countries have driven tobacco companies to increase sales of tobacco products in lower- and middle-income countries.¹² The WHO Framework Convention on Tobacco Control illustrates the types of alliances that are needed to address such health threats on a global scale, again pushing scientists to re-examine the methods, theories and measurement tools that are required to learn from these endeavours.

As we look to the future, we have a unique opportunity in Canada to further develop the science of population health interventions. The conditions for this work have been created through the outstanding efforts of public health workers who have advocated for vulnerable populations and the socially disadvantaged,¹³⁻¹⁶ and by scientists who have deepened our understanding of social determinants and undertaken foundational work relevant to the emerging science of population health interventions.¹⁷⁻²⁰

System supports are required for changes in the delivery of public health services and advances in population health science. The National Health and Research Development Program was the primary supporter of public health research in Canada for 30 years. This laid the groundwork for population health research to be firmly placed alongside biomedical, clinical and health services research when the Canadian Institutes of Health Research was established in 2000. The Institute of Population and Public Health was set up with Dr. John Frank as its inaugural Scientific Director. The first strategic plan for the Institute had a strong focus on understanding and to some extent addressing social and environmental determinants across the life course. With a view to catalyzing scientific inquiry and strengthening the research capacity required for the field of population health science, important initiatives such as the Centres for Research Development and the Applied Public Health Chairs Programs were supported.

The second strategic plan for the Institute, which has recently been launched, has four strategic objectives: a) to further our understanding of pathways to health equity, b) to examine the impact of complex population health interventions on health and health equity, c) to examine how implementation systems for population health interventions may strengthen or weaken the impact of population health interventions on health and health equity, and d) to stimulate theoretical and methodological innovations in knowledge generation, knowledge synthesis and knowledge integration for population and public health. The Institute aims to support population health intervention science that addresses health inequities.

The new science of population health interventions requires that we return to the social justice roots of public health. Funding mech-

anisms that encourage transdisciplinary efforts and bridge paradigms, methods and measures are essential. We need the best and brightest ideas of practitioners, managers, scientists, policy-makers and community partners to tackle the equity gap through interventions in public health and other sectors. Being responsive to the population and public health problems that lie before us requires that we avoid narrowing our approaches to those that are familiar and comfortable.²¹ Our strengths include our understanding of social, environmental and macrodeterminants of health; our roots in social justice; and our concern about improving the overall health of populations while narrowing the equity gap. Our ongoing challenge is how to address these through leading-edge science, and how to approach these in ways that will ultimately benefit those who are experiencing the dark side of material and social disadvantage. We will have succeeded if the history books of this century describe how we inserted social justice into the practice and science of population health interventions in Canada and globally.

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