A B S T R A C T

Population health promotion illustrates most robustly that health is a shared responsibility. Improving our understanding of the social production of health and the purchase population health promotion has on shaping social welfare policy presents a number of challenges to the future development of this discourse. Three are briefly discussed in this paper. First is the matter of language we use to describe our understanding of processes and influences. Second is the conceptualization of the pathways that shape population health status. Finally, cultural practices both extant and required to improve health status and reduce inequalities are addressed.

A B R É G É

La promotion de la santé de la population illustre de façon convaincante que la santé est une responsabilité partagée. Améliorer notre compréhension de la production sociale de la santé et de l'impact de la promotion de la santé de la population sur la structuration des politiques de bien-être social présente un certain nombre de défis pour le développement futur de ce discours. Trois d'entre eux sont brièvement discutés dans cet article. Premièrement, nous notons le langage que nous utilisons pour décrire notre compréhension des processus et influences. Deuxièmement, la conceptualisation des mécanismes qui structurent les états de santé des populations est discutée. Enfin, les pratiques culturelles actuelles et requises pour améliorer l'état de santé et réduire les inéquités sont traitées.

Population Health Promotion: Responsible Sharing of Future Directions

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The past decade has witnessed the emergence of a population health framework with which to try to understand the myriad factors that influence human health and well-being, and to explain why it is that health status is systematically distributed across socio-economic groups within society.¹ The framework is a logical extension of a "big picture" view of health influences contained within the rubric of health promotion. Philosophically, health promotion and population health share the same objectives: to improve the health and well-being of all people in society and to reduce inequalities in health between people. Those advocating specific policies, programs and/or actions in the name of either population health or health promotion are, presumably, motivated by a strong sense of social justice and fairness and genuine concern for collective well-being, even in the face of co-existing (and sometimes competing) motives (economic gain, prestige and career advancement, expedience, etc.). This does not, of course, give immunity to labels. A broad view of health invites the evocation of the labels "health promotion" and "population health" to be associated with all manner of activity, even when activities so described can be shown to be perversions of the very logics the activities claim (the narrow association of health promotion with individual behaviour, for example, or the use of population health to justify neo-liberal approaches to social welfare policy).^{2,3}

Implementing population health approaches to public policy presents innu-

merable challenges to both politicians and public servants. By definition, the "big picture" is complex and whatever is held up as "the framework" is contestable. The time frame of a lifecourse perspective greatly exceeds the temporal horizon of political mandates, and it is extremely difficult to muster support for policy options that make sense from a longer-term perspective but are at present unpopular or threatening to specific interest groups or advocate on behalf of marginalized groups that are not politically/economically powerful. The corporate approach to public policy population health promotion requires effective coordination between and cooperation among various institutional structures (ministries and agencies of various levels of government; community agencies and service clubs, etc.). This is often difficult to establish and maintain. The number of fronts across which health influences operate, and the fragmented social spaces in which influences play out, create too many needs to be completely satisfied and competition between groups for resources. Thus, there are reasons to be pessimistic about what can be achieved through a population health approach to public policy.

Despite these and other problems associated with population health, its importance as a public health policy thrust is paramount.^{4,5} Conferences like the one giving rise to this CJPH supplement provide welcome opportunities to strategize around how we might use our collective human agency to advance actions consistent with the philosophy of population health promotion. An invitation to participate in the National Conference on Shared Responsibility for Health and Social Impact Assessment as a panellist in the concluding plenary on future directions in

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population health in Canada prompted the following comments.

First, language matters.^{6,7} Although they have been described as “heterogeneities in health status,”⁸ the persistent and consistent gradients in health status found in all industrialized countries in fact reflect socially structured inequalities. Gradients do not fall from the sky and are not the random outcome of chance occurrences. They cannot be explained simply by individual “lifestyle” behaviours. Rather, they are produced through the effects of institutionalized systems of distribution of both material and non-material resources.⁹ To be sure, many chance occurrences do influence health experiences in life, such as the chance meeting of people who become life partners and who create (or fail to create) mutually supportive and nurturing familial relationships, or the interpersonal dynamics operating at any particular work site or among any particular cluster of neighbours. The structural aspect of distribution is rooted in the differential probabilities that individuals occupying different locations in a social hierarchy are likely to possess particular skills (communication, negotiation, problem solving, etc.) or encounter supportive and nurturing social relations in their routines of daily life, and the differential access to material resources simultaneously bound up in (producing and recreating) the hierarchy.

Similarly, the phrase “determinants of health” is a misleading expression with which to describe what are actually salient domains of influence. Perhaps the greatest frustration with population health promotion is trying to piece together a coherent explanation of how health status is shaped in the face of the inherently indeterminate nature of everyday life. This is not to say that the domains of influence identified in the list of 12 “determinants” contained in *Sustaining Our Health*⁴ or *Taking Action on Population Health*⁵ are unimportant, or that effective policies for promoting population health cannot be developed. It is simply to recognize that the label is inconsistent with a philosophy of society as an open system of relations in which the necessary conditions for cause-effect determinism found in controlled experiments are lacking.¹⁰ Sloppy use of language can have

important consequences both for public perceptions/conceptions of what the state responsibility is (witness our provincial experiences with the label “Ministry of Health”) and for future research and policy development.

Second, by what mechanisms is health socially produced? The answer to this question, too, requires us to think about the ways in which society is theorized within population health promotion. The list of identified “determinants” reveals a deep conceptual confusion about this. For example, the phrase “social environments” adds nothing to a list that already contains many examples of social environments – income and social status, social support networks, education, employment and working conditions, healthy child development, gender, culture. The gradients indicate that health is socially structured, yet there is very little discussion of social structure in population health.^{3,11} Is structure thought to be almost independent of human agency (as some Marxist accounts – or critiques of Marxist accounts – seem to suggest), or is it conceptualized as both the medium and outcome of individual behaviour?¹² Presenting “determinants” as discrete influences detracts from the need for us to more clearly articulate the conception of society upon which the analysis of population health is based. It also runs the risk of confusing empirical categories of measurement such as educational attainment or income with underlying theoretical or conceptual explanations of processes influencing health. It is not enough to acknowledge the interconnectedness of these domains; we must be more explicit about their web-like nature.

The proposed pathways connecting social influences to biological functioning are believed to operate through what Tarlov calls a sociobiological translation.¹³ On this account, communication between the immune, endocrine and central nervous systems so crucial to regulating biological function and maintaining homeostasis is conditioned by our feelings about ourselves and experiences of our place in a social milieu. Thus, the social production of health involves both material and meaningful dimensions. Power, identity, status and control appear to be crucial aspects of

relational influence, yet again there is little discussion of what is meant by these concepts. Some have suggested that social cohesion and social capital are important pathways for improving population health status,¹⁴⁻¹⁷ yet as presented these notions contain potentially severe conceptual problems.¹⁸ There is, then, much intellectual work to be done within population health promotion, work that involves theorizing social relations and social structure. Although this type of activity has been eschewed historically in health research as “soft science”, a population health framework illustrates that such disdainful attitudes toward social sciences are soft headed and will not move the agenda forward.

A final comment is that the most important challenge facing the future of population health promotion is not political but cultural. How we imagine ourselves and our connections to others, particularly the “distant strangers” who live at the same time as we do and whom we never meet,¹⁹ will fundamentally shape the degree to which population health promotion will be embraced and supported by the public as a basis for making sound social welfare policy. The framework informs us that these connections are crucial to improving health and well-being and reducing health inequalities. If by reducing economic disparities within society overall health status is improved and health inequalities are reduced, the obvious question to ask is how can this be achieved? How can we come closer to creating a culture of nurturing and mutual support, and resist the strong ethos of rugged individualism so firmly entrenched (and apparently growing) in North American culture?²⁰

At the risk of sounding wildly naive, perhaps our best chance for bringing this about is through a concerted communications effort to improve health literacy; that is, to make public the discourse around health and its broad influences in an effort to reconcile public opinion with the weight of evidence concerning population health. The population health framework involves a complex story about the rather ordinary events of everyday life. It does not lend itself to exciting, rapid-fire tales of scientific discoveries and miracle cures, or stories of salvage and salvation. Population health

promotion is unlikely to make financial investors immediately wealthy or to produce a professional class of service providers. It does not make for chilling news reports. And it is likely to be threatening to elite groups who benefit most from the existing order of things. Yet the story itself is quintessentially one of our basic humanity, of our own life experiences. The social gradients implicate everyone, not just the poor, the failed or the vilified. If the framework has any explanatory credibility at all it must resonate with peoples' life experiences. To the extent that a concerted health literacy communications effort is able to reach the public and tell a convincing story that captures the collective imagination, the broad public support required for a population health promotion policy thrust may be generated.

Critical examination of the media and the role it plays in shaping public perceptions about health-related issues could greatly assist a communications strategy. The recent National Post editorial disparaging the merits of a population health perspective illustrates why media scrutiny is required.²¹ Making explicit links between the domains of influence currently referred to as "determinants" and experiences of everyday life would help shift the public discourse away from an obsession with health care and the occurrence of disease toward a more general concern with human well-being. Perhaps it might also lead to a more general public discussion about the basis of civil society, one that embraces attitudes of support, tolerance, respect for the human condition, recognition of the fundamental connections between all members of society, and appreciation of the wisdom of reducing disparities between people.

The population health framework makes it clear that health is most robustly a shared responsibility. Issues of social justice and equity never go away, but they may be responded to in prudent, less violent, more humane ways. Sharing the responsibility for bringing this about involves advocating for the broader kinds of change in social welfare policy that will most improve health and well-being. It involves having the courage to speak out to share the information assembled within the population health framework. It involves having the wisdom to understand and respect our connections with distant others. And it involves having the strength to act upon the information in a way that is consistent with the ultimate objectives: improved health and well-being and reduced health inequalities.

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REFERENCES

1. Hayes MV, Dunn RJ. *Population Health in Canada: A Systematic Review*. Canadian Policy Research Networks CPRN Study No. H01. Ottawa: Renouf Publications, 1998.
2. Poland B, Coburn D, Eakin J, et al. Wealth, equity and health care: A critique of a 'population health' perspective on the determinants of health. *Soc Sci Med* 1998;46(7):785-98.
3. Coburn D. Income inequality, lowered social cohesion and the poorer health status of populations: The role of neo-liberalism. Department of Public Health Sciences, University of Toronto, May 28, 1999.
4. Health Canada, Sustainable Development Secretariat. *Sustaining Our Health*. Ottawa: December, 1997.
5. Health Canada, Population Health Development Division. *Taking Action on Population Health*. Ottawa: H39-445/1998E, 1998.
6. Robertson A. Shifting discourses on health in Canada: From health promotion to population health. *Health Prom Int* 1998;13(2):155-66.
7. Hayes MV. Evidence, determinants of health and population epidemiology. In: Hayes MV, Foster LT, Foster HD (Eds.), *The Determinants of Population Health: A Critical Assessment*. Victoria: Western Geographic Series Vol. 29, 1994.
8. Hertzman C, Frank J, Evans RG. Heterogeneities in health status and the determinants of population health. In: Evans RG, Barer ML, Marmor TR (Eds.), *Why Are Some People Healthy and Others Not?* New York: Aldine De Gruyter, 1994.
9. Wilkinson RG. *Unhealthy Societies*. London: Routledge, 1996.
10. Sayer A. *Method in Social Science* (2nd edition). London: Routledge, 1992.
11. Muntaner C, Lynch J. Income inequality, social cohesion, and class relations: A critique of Wilkinson's neo-Durkheimian research program. *Int J Health Services* 1999;29:59-81.
12. Giddens A. *The Constitution of Society*. California: University of California Press, 1984.
13. Tarlov AR. Social determinants of health. In: Blane D, Brunner E, Wilkinson RG (Eds.), *Health and Social Organization*. London: Routledge, 1996.
14. Kawachi I, Kennedy B, Lochner K, Prothrow-Stith D. Social capital, income inequality, and mortality. *Am J Public Health* 1997;87:1491-98.
15. Kawachi I, Kennedy B. Health and social cohesion: Why care about income inequality? *Br Med J* 1997;314:1037-40.
16. Lomas J. Social capital and health: Implications for public health and epidemiology. *Soc Sci Med* 1998;47(9):1181-88.
17. Veenstra G, Lomas J. Home is where the governing is: Social capital and regional health governance. *Health and Place* 1999;5(1):1-12.
18. Hayes MV, Dunn JR. On the currency of social capital in health inequalities. Paper presented at the annual meeting of the Association of American Geographers, Hawaii, March 28, 1999.
19. Ignatieff M. *The Needs of Strangers*. Harmondsworth: Penguin, 1984.
20. Angus Reid. The tragedy of exclusion. *Angus Reid World Monitor*, third quarter, 1998;27-34.
21. Editorial. The new politics of health. *National Post*, June 7, 1999.