

The two sides of public health

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Sophy Bergenheim’s account (2018) of the approach to social and health policy that goes, sometimes confusingly, under the multi-layered concept of public health, is a very welcome commentary. In her text Bergenheim stresses in historical terms the population-oriented focus of many policy advances applying this notion. Although seemingly referring to a unitary notion of the “people”, *folk*, *kansa*, especially in the Nordic context, the actual implications of public health framing have been less universalist and accepting of differences. The Myrdals used the expression “improving the quality of human material” for policies to improve the health, welfare and working capacity of the nation, part of which contained education and the hygienic conditions of the lowest socio-economic population groups. Many other normative stipulations have been embedded in the notion, as Bergenheim correctly points out.

I wish to make just one (small) objection and two remarks on the use of the epistemic concept of public health since the advent of the New Public Health movement in the early eighties. The objection is to the idea that medicalisation, turning

behavioural issues into matters of health, would contain the individualising implications of neoliberal stress on self-responsibility and choice. In contrast, as one of our unpublished studies shows, public understanding of behavioural problems such as unhealthy dietary patterns, gambling, substance use and other excesses, as “diseases” or conditions requiring medical attention, often tends to define the subjects of such behaviour as objects requiring expert methods of treatment, not as agents responsible for their own conduct.

My two additional remarks relate to the double nature of public health framing. The first concerns the way in which the notion of public health in some definitions already embeds certain social aspects. The New Public Health movement reacted to a fundamental change in the concept of health. Health is no longer to be understood as absence of disease; it is rather a condition of degree that can be greatly improved by society, not only to provide treatments but also influencing the environments in which people live. The Ottawa Charter on health promotion of 1986 describes this well: “To reach a state of complete physical mental and social

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wellbeing, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment” (World Health Organization, 1986, p. 1). Health is not a condition, it is a capacity to improve one’s subjective and objective wellbeing, and health promotion thus covers efforts not so much to make individuals care for themselves as to facilitate this potentiality.

Health promotion is not only education and information; it also covers tobacco policy, environmental issues, accessibility of public space, and many other things that are beyond the power of individuals. This, like the WHO campaign Health for All, has been and still is an important programme to justify efforts to improve water and nutritional conditions, anti-poverty and anti-inequality policy, and other concerns that are related to loss of health. The WHO approach to measuring the impact not only of different diseases but also lifestyle patterns on disability-adjusted life-years lost through premature mortality in the Global Burden of Disease collaboration, is part of this orientation. In this sense, the New Public Health movement stays rather close to the dispositions of mid-19th-century hygienists, who worried about sewage, air pollution, availability of clean water and non-contaminated food, especially in growing urban-industrial conglomerations such as Paris or London.

The difference is that today contagious diseases, provoked by inferior hygienic conditions, are far less important than so-called non-communicable diseases, called so for historical reasons but actually referring to everything that lifestyles, consumption and living conditions are responsible for. This extends the category of health to cover a wide variety of social issues, including inequality. There is an advantage to this. Such issues tend to involve political and cultural disputes, especially that of the freedom of markets and consumers; justifying policy under the rubric of health puts it in a framework that few would object to. Health, security and wellbeing, are goals and values that all or most of us can accept for ourselves and our near ones, and even for less proximate

people, as something to be desired even if a price has sometimes to be paid for them in terms of freedom to choose our lifestyle and the necessity of tolerating the lifestyles of others.

My second remark concerns the disadvantage with the epistemic framing of public health. Putting policy goals under the umbrella of “health” smuggles in an epistemological commitment to causality. Limiting the sales hours of alcohol, raising the price, blocking IP addresses of gambling operators, or taking away gambling machines from bars and other public spaces will require proof of impact on rather abstract variables that can be entered into measures of the health of the people (whoever they are). Such evidence is not always easy to establish. Consequently, the justification of policy may fall prey to easy arguments of non-existing proof, eagerly presented by stakeholders such as the industries and distributors of their products. Yet, the moral and social issues may be flagrant, if not compressed into concepts that appear neutral but measurable, such as population “health”.

Distributing money to the rich through gambling from the poor by selling hope to those who have little of it may never be demonstrated to be a health problem in any sense for any conceivable population; still, it should raise concern, and arouse questions about fairness and justice, and the true motives of protesting against it.

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