

# Should a definition of public health include social welfare?

## The case for and against

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Public health, as today's physicians have come to understand it, is a concept that extends beyond the control of infectious disease and harmful pollutants to encompass social welfare and advocacy.<sup>1</sup> The concept that physicians and healthcare organizations have a professional duty to advocate for social, economic, and political reform as a method to alleviate population-wide determinants of health dates back to at least the 1940s, when the newly founded World Health Organization (WHO) defined health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."<sup>2</sup> The WHO definition continues to exert influence despite the criticisms it has drawn over decades. This definition rightly assumes that health is not merely a negative concept—the mere absence of disease symptoms—but that it must comprise something more. In modern medical education, this definition has been interpreted as a professional responsibility for physicians to look beyond the direct patient interaction and to become advocates and agents for the reform of economic inequalities, discriminatory social institutions, and cultural prejudices.<sup>3,4</sup> In this article, the authors call for a debate about the merits of this public health paradigm.

### THE CASE AGAINST IT

The approach to healthcare that is implied by the World Health Organization's (WHO) definition has won many adherents, yet it also has its share of critics. Surprisingly, some of the most powerful arguments that critics have been making since at least the 1970s remain only partially addressed by proponents of the current healthcare paradigm.

There are two fairly straightforward criticisms, which may be stated briefly.<sup>5</sup> In the first case, suggesting that broader social and economic reform is within the scope of modern medicine may ascribe too much authority to physicians. Physicians are not politicians. A separate criticism is that such a conception of public health vastly expands our ordinary notion of "health" to include potentially most of what we would normally understand to constitute human happiness. Indeed, what human goods, whether individual or social, might *not* be understood to fall within a state of physical, mental, and social well-being that is "complete"? Both criticisms remain weighty objections that must chasten the reformist zeal of any physicians who claim the authority to take leadership roles in institutional reform as their professional prerogative. Nevertheless, these two criticisms do *not* decisively nor necessarily defeat the social welfare idea of public health. Nothing prevents physicians from informing themselves

and becoming more expert in public policy matters. On the contrary, well-informed physicians who understand the inherent limitations of the perspective of their profession could be a valuable voice in public policy debates. As long as professionals keep in mind that health is distinct from broader concepts such as subjective happiness, and that it is only one precondition of a full human life, we will avoid confusion regarding the fundamentals.

Beyond these more or less straightforward criticisms, however, there are more profound philosophical objections that challenge the current public health paradigm in a more radical way. Several decades ago, Ivan Ilich argued that by transforming pain, illness, and death into a set of purely technical problems, to be addressed over time by medical science, we have made these problems not more, but *less* manageable.<sup>5</sup> According to Ilich, modern medicine has sold the public a false bill of goods: for at least a century it has held out the promise of an ever-increasing lifespan and of the eradication of an increasing number of devastating diseases. This promise has proven to be only an illusion: the diseases we have eradicated (small pox, measles) have been replaced by new ones (cancer, obesity, mental illness). Yet not only have we replaced one set of illnesses with another; perhaps more importantly, we have also rendered ourselves complacent regarding the inevitability of our mortality. The illusory belief that with sufficient advancement in medical science we will one day be able to conquer pain and disease has gradually led our society into a perpetual denial of the need for each one of us to face the inevitability of disease, and ultimately death. Conversely, according to the conception of health favoured by Ilich himself,

[h]ealth designates a process of adaptation. It is not the result of instinct (ie, to avoid pain), but of autonomous and live reaction to an experienced reality. It designates the ability to adapt to changing environments, to growing up and to ageing, to healing when damaged, to suffering and to the peaceful expectation of death. Health embraces the future as well, and therefore includes anguish and the inner resource to live with it.<sup>5</sup>

In addition to traditional modes of medical intervention, "welfare, international relief, and development programmes are enlisted in this struggle" to obscure the true problem of health—the expansive, social welfare idea of public health would rob us of the humane task of coming to terms with our fate as mortal beings.<sup>5</sup>

## ETHICS & LAW

### THE CASE FOR A SOCIAL WELFARE IDEA OF PUBLIC HEALTH

Article 27 of the Universal Declaration of Human Rights, adopted by the United Nations General Assembly, states that everyone has the right to share in scientific and medical advancements, and their benefits.<sup>7</sup> The International Covenant on Economic, Social, and Cultural Rights includes the right to health as a basic right, and the definition also includes the right to the social determinants of health, such as housing and nutritious food, with the understanding that they contribute significantly to health outcomes.<sup>8</sup> This is a key point. There is considerable evidence to suggest that the process of neoliberal economic policies and globalization has hollowed out the health systems of the Global South and made the poor ever poorer.<sup>2</sup> Increasing privatization and trade reforms have made access to healthcare difficult, and have also reshaped access to the social determinants of health, such as food and housing. For instance, neoliberal trade reforms have damaged local food security in the Global South by encouraging a shift to store-bought food away from local food,<sup>8</sup> which in turn has not only resulted in an increase in prices, but also in the incidence of diabetes and obesity.<sup>8</sup>

Human rights, and especially a rights-based approach to health, offer an alternative to neoliberal policies<sup>8</sup> in that they eschew cost-effectiveness when it comes to human life. Instead they posit that doctors can, and should, advocate for policies that consider the social determinants of health. Healthcare providers can lessen the impact of social inequalities, especially since the natural history of disease encompasses social phenomena.<sup>9</sup> For example, tuberculosis disproportionately affects First Nations, partly due to cramped living conditions and the poor ventilation found in substandard housing on reserves, which has risen as a result of a history of governmental neglect and historical circumstances. Simply treating tuberculosis in this situation will not address the social determinants of the illness.<sup>9</sup> Although Rene Dubos may have expressed doubt in the lack of training that physicians have in political advocacy, he also mentions repeatedly throughout his book *Mirage of Health* that one cannot forget that improvements in socioeconomic conditions since the 19th century have been the true major cause of the decline in the incidence of communicable diseases in the Western world.<sup>10</sup> The reform movements of the 19th and 20th centuries directly took on the poor living conditions that lead to such unconscionably high incidences of diseases, such as tuberculosis and cholera, amongst the working classes. One of the doctors at the forefront of the reform movement was none other than Rudolf Virchow, who was a pathologist and civic and public health reformer. Virchow is famous for having said that “physicians are the natural attorneys of the poor.”<sup>7</sup>

Dr Paul Farmer has perhaps been the one health scholar who has been able to clearly articulate the rationale for a rights-based approach to health, and its demands on physicians. He has been able to meld liberation theology’s demands for the rights of the poor with conventional human rights analysis and work, and thus refocus our attention on social justice and towards the fundamental moral equality of all persons.<sup>5,11,12</sup>

Dr Farmer’s writings are primarily concerned with the upstream social determinants of health, specifically with those factors that he defines as constituting a form of structural violence. Structural violence refers to social structures that stop individuals, groups, and so-

cialties from reaching their full potential.<sup>8</sup> It is related to the concept of structural oppression, which more generally speaks to socioeconomic conditions such as poverty and racism that lead to the violations of people’s civil, political, and economic rights. For instance, although the Canada Health Act guarantees access to healthcare with no direct nor indirect barriers, the existence of historically underserved populations, such as the First Nations or the lesbian-gay-bisexual-transsexual-queer community, give evidence to the fact that in practice, these groups as well as many others have been effectively disenfranchised of their right to health.

Structural violence is a powerful concept in understanding the pathology of society’s ills. It challenges the community of medicine to understand that although vulnerable populations are offered formal rights in Canada or abroad, the actual enforcement of those rights is spotty at best. The concept of structural violence also posits that even where civil and political rights are equally exercised (freedom of speech, association, etc), disparities in economic rights, such as a right to an education, to housing, and to health, affect people on a more substantive level.<sup>6</sup> It is in this vein that Dr Farmer advocates for approaching the diagnosis and treatment of diseases as a public good.<sup>5</sup> Medical services are not just commodities to be purchased and delivered—indeed this is the core belief of a rights-based approach to health.

In conclusion, the inextricable link between the natural histories of diseases and socioeconomic factors, such as race and poverty, demand that physicians advocate and work to ameliorate those factors that continue to perpetuate and maintain disease. Physicians should certainly understand the lack of training in politics that most of them have, as well as be humble about their ability to significantly treat the socioeconomic determinants of health.

### REFERENCES

1. Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.
2. Dos Anjos MF. Medical ethics in the developing world: a liberation theology perspective. *J Med Philos.* 1996;21:629-37.
3. The Association of Faculties of Medicine of Canada. AFMC primer on population health [Internet]. Ottawa (ON): The Association of Faculties of Medicine of Canada; [cited 2014, Aug 19]. Available from: <http://phprimer.afmc.ca/>.
4. Callaghan D. The WHO definition of ‘health.’ *Hastings Cent Stud.* 1973;1(3):77-87.
5. Illich I. Medical nemesis. *J Epidemiol Community Health.* 2003;57(12):919-22.
6. Farmer PE. Pathologies of power: rethinking health and human rights. *Am J Public Health.* 1999 Oct;89(10):1486-96.
7. Chapman AR. Globalization, human rights and the social determinants of health. *Bioethics.* 2009 Feb;23(2):97-111.
8. Farmer PE, Nizeye B, Stulac S, Keshavjee S. Structural violence and clinical medicine. *PLoS Med.* 2006 Oct;3(10):e449.
9. Dubos R. *Mirage of health.* New York: Harpers; 1959.
10. Farmer PE. *Pathologies of power: health, human rights, and the new war on the poor.* Berkeley: University of California Press; 2005.
11. Engler M. Toward the ‘Rights of the Poor’ human rights in liberation theology. *J Relig Ethics.* 2000;28(3):339-65.