

Help or hindrance? Social policy and the 'social determinants of health'

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Abstract

In recent years, public health research has become increasingly focused on issues of social inequality and social disadvantage. This is because social issues, such as poor housing and unemployment, have been found to impact health significantly, and are now referred to as 'the social determinants of health'. As a result of this shift, public health is now principally concerned with what are historically considered to be social policy issues. This paper discusses the confluence of public health and social policy; it examines the opportunities and risks posed by this convergence for those working in social policy seeking to reduce poverty and inequality. We argue that, while much can be gained in the two fields by working more closely together, there remain fundamental differences in perspectives and approaches. In order to maximise benefits, these points of difference need to be thought through sooner rather than later.

Keywords: social policy, public health, nonprofit organisations, policy, social welfare

Introduction

The term 'social determinants of health' refers to any social condition that has an effect on health. The World Health Organisation, for example, defines social determinants as the 'societal conditions in which people are born, grow, live, work and age' (WHO 2011:1; CSDH 2011). The social preconditions of health, such as housing, education and employment, are today a central focus of public health research and advocacy (CSDH 2008; Raphael 2008; RWJF 2009). Public health research has demonstrated persistent statistical associations between social conditions and health: people of higher socioeconomic status consistently exhibit better health than those who experience less favourable social conditions (Marmot et al. 2010). In Australia this research – referred to as social epidemiology – tells us that there is a six-year gap in average life expectancy between those in the top and bottom income quintiles (Begg 2008).

Despite a lack of robust evidence that inequalities in social conditions actually *cause* inequalities in health, rather than merely being correlated with them, public health advocates refer to social conditions as being the causes of the causes of ill-health (Link & Phelan 1995); they maintain that continued failure to address these foundational causes precludes the possibility of resolving or ameliorating the unequal distribution of health (Marmot et al. 2010). In line with this position, there are numerous reviews of 'social determinants of health' advocating such changes as fairer education systems or more generous welfare regimes (see, for example, CSDH 2008; Marmot et al. 2010).

As international support for the social determinants of health continues to grow (see WHO 2011b), these discourses and ideas have found fertile ground in Australia. Last year (2013) saw the establishment of the Australian Social Determinants of Health Alliance – now with over seventy organisational members – and the Senate Inquiry into the Social Determinants of Health. The Senate Committee acknowledged the consequences that social factors have for health outcomes, highlighting that: 'By addressing the social determinants of health that are the genesis of many health problems, the costs to government of providing healthcare can be reduced, and individuals can enjoy better health outcomes' (Parliament of Australia 2013). It is worth noting, however, that Commonwealth government intervention explicitly aimed at improving the social determinants of health has, to date, been very limited.

Traditionally, addressing the social factors now designated as social determinants of health has been the concern of social policy (Hill & Hupe 2009). Social policy – as both a field of practice and research – is concerned with what governments do, or do not do, to provide for the wellbeing of citizens, taking in issues such as housing, welfare, health, and aspects of the labour market. A diverse range of actors are engaged in the social policy field including researchers, practitioners, and policymakers. Often members of the community sector are closely involved in social policy as practitioners charged with implementation and delivery of social welfare programs, thereby cross-cutting – but not encompassing – social policy issues.

Despite the late entry of public health into this field, its engagement with those working across social policy – including researchers, practitioners and policymakers – has been inconsistent. At present, public health and social policy research are largely disconnected fields, notwithstanding their increasing preoccupation with the same problems and their being faced with the same challenges.

On the surface, this convergence of interests across public health and social policy seems favourable towards the prospect of developing a consolidated approach to confronting the social determinants of health. Addressing disadvantage and inequality has long been the concern of social policy professionals and programs, and public health is a powerful ally. Moreover, public health has brought new empirical research to the existing evidence base on the effects of poverty and inequality, documenting persistent differences in mortality and life expectancy according to income (AIHW 2010; 2012), education (Cutler et al. 2010; Gakidou et al. 2010; Strand et al. 2002), occupation (Bosma et al. 1997; Stringhini et al. 2011), race (Hummer et al. 2011; Laveist & Lebrun 2010; Shepherd et al. 2012), gender (Ballantyne 1999) and social capital (Szreter et al. 2004; Kawachi et al. 2008; Dominguez & Arford 2011). However, precisely because public health is a powerful ally, social determinants discourses pose a number of risks to those working in social policy, including a tendency to collapse complex issues of inequality and disadvantage into ‘health’ problems, and to advocate for solutions that are very health-centric.

Through examining the history of public health and the current state of public health research and advocacy, in this paper we consider the opportunities and risks social determinants of health discourses pose for those working in social policy. Here, we refer to all actors involved in shaping the welfare state – from researchers, to policymakers, to practitioners in the community sector. However, within this broad field we pay particular attention to practitioners involved in the provision of – and advocacy for – welfare relief, found within the community services sector. This is because emerging social determinants of health discourses have especially profound consequences for this group.

A social history of public health

Organised attempts to protect the health of the public date back to the earliest known societies. The modern science of public health, however, has its roots in mid-nineteenth century England (Porter 1999; Rose 1958). In the filth of industrialising London, public policy was preoccupied by what Carlyle dubbed the ‘condition of England question’: what to do about the poverty of the working and lower classes (Hamlin 1998). This question was hugely controversial, with influential figures and thinkers taking starkly different positions. Thomas Malthus famously argued that the poor should be considered ‘surplus’ population and be allowed to die, while utilitarian Jeremy Bentham fought for the overall benefits conferred by the rudimentary welfare system in operation at the time (Malthus 1798; Bentham 2011).

From this early social policy debate, public health emerged as a peculiarly uncontroversial way to resolve at least some facets of the controversy (Hamlin 1998). For hundreds of years English law had distinguished between people who were unable to work due to age or infirmity – who were regarded as worthy recipients of welfare – and those who were physically able, and thus unworthy recipients (Ault 1930; Poos 1983). Even deliberately punitive laws that banned vagrancy on pain of death allowed for those who were sick to access publicly funded relief (Vagabonds Act 1535; Vagabonds, etc. Act 1547). Disease was delivered by providence and therefore was beyond the culpability of the individual, whereas indolence was an entirely individual trait (Petty 1662).

As living conditions in cities deteriorated with the rapid urbanisation accompanying early industrialisation, infectious disease became ever more prevalent (Hamlin 1998). Early statistical studies demonstrated that death from disease was more common among the working classes and that overall life expectancy for labourers was up to twenty years lower than that of the middle class (Eyler 1979). In Manchester in 1840 the average age of death for the gentry was 38; the average age of death for labourers was 17 years of age (Chadwick 1842). The long-held protection for the sick meant that as men and women fell ill they were supported by government 'welfare', despite the fact that this meant that, as well as denying England the fruits of their labour, they also became a drain on the public purse, which paid for their medical attention.

The ability of public health to cut through tumultuous social policy issues and questions concerning citizen welfare is best demonstrated by Edwin Chadwick, public health reformer and architect of England's first *Public Health Act*, passed in 1848. He wrote to a friend in 1840 that he initiated his inquiry into sanitation 'when a heavy amount of claims to [public] relief appeared as a consequence of the prevalence of an epidemic' (Flinn 1964:2). That is, the single most important public health intervention of the nineteenth century – the public provision of sanitary infrastructure – was implemented in order to save government expenditure.

What is striking about the introduction of public health legislation into England, as it relates to this paper, is how much less controversial it was than legislation on working hours and conditions (Golding 2006; Hamlin 1998). Workers fought desperately to win shorter working hours, safer working conditions, and increased wages, and were staunchly opposed by most in power (Finn 1993; Goodway 1982). Each of the *Factory Acts* was incredibly hard-won by the working class. In contrast, the *Public Health Act 1848* passed into law without opposition; regardless of any unstated argument that it might increase labour productivity and reduce government expenditure on the sick, it would nonetheless require the Crown's support for the establishment of local boards of health and the provision of loans for public sanitary infrastructure (Flinn 1964).

The strength of public health, then as now, relied upon empirical evidence, which was presented and interpreted as being largely independent of political and ideological dispute. For example, Chadwick proposed the provision of public sanitary works on the basis that it would reduce disease – the fact that

this served other interests was left unstated. Similarly today, social determinants of health advocates argue not that income inequality is unjust, but that it is empirically proven to be damaging to health (Wilkinson & Pickett 2009; Pickett & Wilkinson 2009) For them the evidence takes precedence over ethical considerations and is argued to be essentially morally neutral (Venkatapuram, Marmot & Bell 2010). Although social determinants of health research and advocacy have not yet been as successful in skirting controversy as was Edwin Chadwick, the field certainly claims the same empirical objectivity over what are otherwise strongly contested areas of social policy and the welfare state. In a range of areas, these claims have been used to justify much intrusive regulation as necessary in the name of public health. The many layers of regulation of tobacco products, for example, which include hefty taxes on a product predominantly used by the poor, are generally considered to be uncontroversial. The list of public health regulations is extensive, from relatively minor restrictions such as seatbelt, helmet and product safety laws through to extremely powerful infectious disease controls that grant governments the compulsory power to quarantine.

Contemporary public health

Today, public health research and its resultant evidence is considerably more detailed than early observations in the nineteenth century, and provides two key insights into inequity and disadvantage. The first and most obvious contribution is to discover and document the health consequences of being disadvantaged. In Australia we know, for example, that alongside the twelve-year gap in life-expectancy between indigenous and non-indigenous people there is a six-year gap between those in the top and bottom income quintiles, and a four and-a-half-year gap between those who have and those who have not completed more than 12 years of schooling (Clarke 2011).

This evidence tells us much about the consequences of disadvantage. The research on social capital, for example, demonstrates that the loss of social cohesion lamented in social science literature (Putnam 2000) is also detrimental to health. People who have limited engagement with their local communities report lower self-rated health and higher overall mortality than those enjoying greater social participation (Murayama et al. 2012).

The second contribution is the discovery of the ‘social gradient’ of disease. From the 1970s onwards there has been an accretion of evidence that the health consequences of disadvantage are not limited to those in the bottom five or ten per cent of society. Rather, for every move upwards in income, education, or occupation, there is a concomitant benefit to health (Marmot 2010). That is, the upper class does better than the middle class which, in turn, does better than the working class. The social gradient demonstrates that the effect of status upon health persists beyond levels of absolute poverty and into the relative wealth of the middle class. This phenomenon of ‘relative deprivation’ challenges the dichotomy of privileged/disadvantaged, forcing recognition that there is a spectrum of advantage, with detrimental health consequences for all but those at the very top of society.

The history of public health reveals the ability of public health advocates, and public health as an issue, often to cut through highly contested policy debates over the role of government in providing for the welfare of citizens.

The social determinants of health – opportunities & risks

Drawing on the history of public health provided above, in the following section we explore the opportunities and risks of current public health research and discourse for those working in social policy research and practice.

The imperative of health

The provision of services and support for citizens – or the existence and scope of the 'welfare state' has been a contested issue in Australia since Federation, accompanied by many value-based tensions and debates (Mendes 2008). Pre-Federation, approximately twenty per cent of the Australian population lived in poverty (Mendes 2008). As governments came to realise that poverty was a product of social and economic conditions – rather than individual behaviour – they began to take up a greater interventionist role to address it (Garton 1990). Thus, the Australian welfare state has its roots in welfare relief, as opposed to what Titmuss (1958) called an 'institutional welfare state'. Titmuss (1958) defined institutional welfare states as revolving around the principles and objectives of universalist social services. Institutional welfare states therefore provide for the entire population by means of universal support and services. Australia, however, favours residual and means-tested policy, which typically comes into play when other forms of welfare – for example, family and voluntary welfare – fail (Reynolds 2000). Arguably, this targeted approach has led to a political and social preoccupation with 'which citizens' are entitled to 'what level' of benefits (Mendes 2008). This can be seen most prominently in contemporary debates over unemployment benefits and welfare dependency (Mendes 2008).

Defined in its broadest sense, the 'welfare state' refers to the state-protected standards of income, health, housing, education, personal social services, and the efforts of government to promote equality (McMahon 2000). As suggested by Bessant, Watts, Dalton & Smyth (2006:1), 'The welfare state refers to what governments do ... with the intention of improving the welfare or happiness of people': it encompasses the actors – government departments, agencies and non-government organisations – policies and programs used by governments to improve directly the wellbeing of citizens. Predominantly, this involves the creation and implementation of 'social policy' (Hill & Hupe 2009; Bryson 1992).

While some scholars (see Epsing-Anderson 1990) contend that this is the truest – or most ideal – definition of the welfare state, in recent years concepts of welfare and the welfare state have been increasingly used to refer to a subset of welfare directed at the most needy, or the *minimum* level of government-led provisions provided to those experiencing poverty or disadvantage (Bryson 1992). In other words, 'welfare state' is used largely to refer to the provision of *welfare relief*, such as welfare benefits. However, welfare relief is merely one component of the welfare state that provides for those most in need. In this paper we examine what

social determinants of health concepts mean for those concerned with the welfare state as a whole, as well as with the subset of welfare relief. Within this second area of social policy, we give particular attention to the implications of emerging discourses regarding the social determinants of health for the social service sector. By ‘community services sector’ we refer to the non-government organisations involved in the provision of welfare relief to citizens – this sector plays an active role in advocating for welfare state change. We consider this sector in particular because the social determinants of health have the potential to impact significantly on the work of these organisations.

While the State’s responsibility to provide for the welfare of its citizens has been – and remains – contested, this has been less so in the area of health policy. This is not to discount controversy regarding the provision of universal health care. Instead it is to highlight that, as Foucault (2004:6) argues, ‘We live in a [world] that sees the care of the body, corporal health, the relation between illness and health, etc. as appropriate areas of State intervention’.

Government expenditure on health now makes up 19 per cent of government budgets, both state and federal (Daley 2013). In fact, governments spend more money on health than on any other area. Moreover, expenditure on health is growing rapidly, having increased by 46 per cent over the last decade (Daley 2013). In contrast, in 2010/11 the federal government spent eight per cent of gross domestic product on welfare, including both cash handouts and services (AIHW 2013). Unemployment benefits – the most contested area of welfare spending – made up only five per cent of total government spending on welfare, or 0.004 per cent of the entire budget (AIHW 2013). Welfare spending, including income support, has also increased at a much slower rate than health care, at just three per cent over the last decade (AIHW 2013). Yet, as Mendes (1998:1) argues, spending on welfare relief ‘has been the foremost issue in the minds of those who wish to reduce state intervention and enhance the importance of the market place’.

As we outlined in our history of public health, government action on health is seen as being in the best interests of both citizens and economic productivity. While healthcare is technically part of the welfare state, and therefore part of ‘welfare spending’, the primacy given to health means that it manages to sidestep many of the moral debates that surround the provision of welfare. For example, in contrast to those receiving welfare benefits, people accessing the public health system are rarely if ever demonized, while people unable to access public healthcare tend to be represented as victims of poor state intervention, subjected to unreasonable waiting times and a lack of infrastructure (see for example, *Herald Sun* 2013). In part, this may also stem from the less-contested nature of the concept, compared to ‘disadvantage’ and ‘poverty’.

In linking health and welfare, social determinants of health discourses provide those interested in social policy change with new means with which to argue for the creation of an expansive welfare state. For those concerned predominantly with welfare relief – such as the community services sector – it can create potential new inroads into government and policy. For example, the evidence

base on the social determinants of health can be used to reframe social policy issues and welfare relief as a substantial investment in the overall health of the population. Building the connection between a strong welfare state and health may help to reframe welfare spending as part of citizens' 'right to health'.

According to Epsing-Anderson (1990), welfare states of different countries can be classified into three broad groups: liberal, social democratic, and conservative. Drawing on this work, public health has found that health outcomes appear to be affected by whether a country belongs to the liberal, conservative, or social democratic grouping. In particular, liberal and conservative categories have been found to perform worse on a range of key health indicators compared to their social democratic counterparts (Epsing-Anderson 1990). For example, Coburn (2004) found infant mortality rates in Finland and Norway in 1995 were 1/1000 (the number of deaths under 1/1000 live births) and 2/1000 respectively, compared with 17/1000 in the United States and 12/1000 in the United Kingdom (Coburn 2004). A recent systematic review of this welfare typology and health outcomes research has found that, as a whole, this body of research provides sufficient evidence that countries with social democratic welfare regimes fare better than their liberal counterparts in terms of health outcomes – arguing that when it comes to the welfare state, 'bigger is better' (Brennenstuhl et al. 2012).

The social determinants of health also serve to shift the persistence of inequality and disadvantage away from being a problem – and a responsibility – of the individual to one that negatively impacts the entire population (Wilkinson & Pickett 2009). Research on social determinants has linked high levels of inequality to increases in crime, morbidity and mortality across whole populations (Wilkinson 2006; Wilkinson & Pickett 2009). This evidence is controversial and has been contested by both those within public health (Lynch and Davey Smith 2002; Lynch et al. 2004) and those outside the discipline (Deaton & Lubotsky 2003; Leigh 2009). Notwithstanding this, the argument that inequality is a population characteristic affecting everyone has gained considerable traction in public health. These discourses position issues of welfare relief and the provision of social services as a problem affecting the breadth of the population, not just those individuals requiring greater state assistance, reinforcing the need for strong state intervention.

In their efforts to secure investment in citizens' welfare, Smyth & Buchanan (2013) have recently attempted to cement the links between welfare and economic growth (that is, welfare as 'social investment') in Australian debate. Historically, 'health' has been more successful than social policy issues at capitalising on the economic and productivity concerns of governments. Since the nineteenth century, health, economic productivity and economic growth have been seen as intrinsically interlinked (Lupton 1995). In part, this helps to explain the primacy health is given over other issues when it comes to state intervention. The social determinants of health discourse can help to draw the connection between welfare investment and economic growth. We are increasingly able to acknowledge and identify the processes by which health is driven by social issues and social inequalities: causative relations that are addressed through the welfare

state, particularly through the provision of welfare relief. Thus, economically productive societies are powered by healthy populations that are created through good education and training, appropriate housing, and stable employment. It is also worth noting that questions remain over whether social determinants of health discourses can have the same purchase as more mainstream approaches to health.

Same problem, different approach

To build a strong evidence base that demonstrates the importance of public health investment, public health has worked to expand and apply experimental methods traditionally associated with bio-medicine, such as randomised control trials, to social and public health problems. Inter-country reviews have found that randomised control trials and experimental approaches have been underused in social policy research, particularly in Australia (MacIntyre 2011; Roberts et al. 2008). While social policy research on poverty and disadvantage has generated a substantive and important evidence base on levels and patterns of inequality, the application of experimental measures at the program level is relatively rare (Roberts et al. 2008). However, in Australia this is beginning to change. For example, in 2012, Sacred Heart Mission launched an intensive randomised control trial of long-term homelessness services (Johnson et al. 2012).

As is often argued in social policy, experimental methods such as randomised control trials were historically seen as an ill fit for evaluating public health interventions and health promotion programs (Hawe, Shiell & Riley 2004; MacIntyre 2011). This was particularly the case when programs relied on community development approaches, and consequently looked very different in different communities (Hawe, Shiell, Riley & Gold 2004). Here, randomised control trial designs were considered incompatible due to the level of ‘context adaptation’ needed in order to apply programs to function effectively in different places (Hawe, Shiell & Riley 2004). However, the application of experimental techniques to public health has seen the development of new ways of thinking about and understanding both the impact of programs on communities, and the concepts used to measure them. Concepts deriving from complexity science have helped public health experts to understand programs as ‘events in a system’, creating new relationships, structures and ways of working that may lead to better health outcomes and results that outlast the program (Hawe, Siell & Riley 2009). Here, experimental concepts such as ‘standardisation’ have been reframed. For example, there has been a shift away from focusing on the fidelity of the product – such as in a drug trial – to the fidelity of the *process*; rather than an information kit or counselling intervention, the steps in the ‘change process’ are standardised. This might be achieved, for instance, through means of stakeholder engagement workshops that adopt different forms with different participants according to local context. Such an approach allows for programs and policies to work flexibly in local contexts, but still enables the systematic collection of data. These insights have helped to build a more robust evidence base for public health programs, which has led to considerable investment in public health (see for example, Australian National Preventative Health Agency

Act 2010; Victorian Healthy Together Communities Initiative 2010). Combining this approach with existing research on the impacts of policies and programs on poverty and inequality has the potential to deepen knowledge of how social policy programs targeted at particular communities or groups work, providing a stronger foundation for policy advocacy.

Recently, public health has also begun to give attention to 'practice-based evidence', in contrast to 'evidence-based' practice or policy, in which the emphasis is placed on the need for improving the uptake of scientific knowledge from research into practice. Practice-based evidence seeks to harness the complexity of real-world encounters with individuals to assist in overcoming research-practice gaps, suggesting that evidence should be created closer to practice (Gabbay & May 2011; Green 2008;). In public health, this has seen researchers working closely with practitioners in order to understand the nature of their practice, and to use this as a foundation for policy change. This 'bottom-up' approach to evidence could serve the community services sector well. Exponents of the community services sector have often argued that it is under-resourced and that their work is underappreciated by government (Australian Productivity Commission 2009). In joining the push for practice-based evidence, and systematically documenting the value of their practice, social service practitioners could strengthen the platform from which to make these arguments.

Finding pathways for change

Perhaps the most significant contribution public health has made to research on inequality is the concept of the 'social gradient'. As discussed in our history of public health, the social gradient demonstrates that 'status' effects health at all levels – from absolute poverty through to relative wealth (Marmot 2010). In doing so, this research has highlighted the issue of 'relative deprivation', with proponents arguing that there is a need to move beyond a dichotomous view of social disadvantage, where, for example, we are concerned primarily with the very wealthy and the very poor. Based on this research, prominent public health advocates are promoting the concept of 'proportionate universalism' (Marmot 2010). Here, policy action occurs across the gradient, but with a 'scale and intensity that is proportionate to the level of disadvantage' (Marmot et al. 2010:15); services are delivered universally, but different groups are provided with differential levels of support according to need. It is argued that this approach maximises benefits across the whole population (Benach et al. 2013), because targeted, residual approaches, focused on the most disadvantaged, are by definition palliative (Rose 1985; McLaren, McIntyre & Kirkpatrick 2010). As a result, investment is required to be indefinite because risks are managed rather than prevented. In other words, no efforts are made to stop those higher up the social gradient from slipping into the bottom social stratum. For those working in welfare relief, this concept can be challenging, as resources are not automatically funnelled to those most in need.

This raises the concern that those working in social policy may not agree with the solutions advocated by public health, and as a result risk being subsumed

by a powerful and prevailing sector. With its focus on evidence-based policy, the social determinants field is working on a different conceptual level to key social policy practitioners, such as the community services sector. In the social determinants of health field, change is often pursued by appealing to policymakers on the basis of population-level data (Coburn et al. 2003), creating heavy reliance on scientific knowledge as a persuasive tool. Here, change is perceived to be brought about by scientists presenting evidence to policymakers. As Coburn et al. (2003) argue, this is highly problematic when the data presented is at the population level and built on abstract statistical models (see for example, Marmot et al. 2010). These data are not closely linked to the real lives and contexts of individuals. Hence, the models that underpin the social determinants of health movement are ‘unable to address the ways in which people individually and collectively act to improve their health’ (Coburn et al. 2003:393). As a result, they do not easily identify pathways for action. Arguably, if solutions were pursued collaboratively, those working at the coalface of social policy – particularly the community services sector, but also a number of government institutions – would be well-positioned to strengthen the explanatory models used in social determinants of health. They would be able to achieve this by advancing a nuanced appreciation of peoples’ lives and the factors that facilitate or enable them to improve their social circumstances and, in turn, their health. In doing so, they could begin to build a picture of the circumstances that produce particular relationships between social factors that impact health, such as housing stress, underemployment, and social participation.

It is important to note that while public health has amassed a sizable evidence base on the links between social issues and health, when it comes to the solutions, knowledge is sparse and action is very much in its infancy (Mackenback 2011; Rainham 2007; Petticrew et al. 2005). Bambra and colleagues (2010) argue that the literature on the social determinants of health has two significant shortcomings: (1) the evidence base is predominantly descriptive, and has not afforded sufficient attention to potential interventions or levers for change; and (2) existing intervention research has been too focused on individual lifestyle factors, rather than the broader social and structural issues that lead to poor health.

Despite the lack of research indicating solutions, public health has forged ahead with the design and implementation of government change programs. While some of these proposed changes are consistent with recent shifts in social policy and public administration, such as an emphasis on ‘joined-up government’ and cross-sectoral collaboration (Marmot 2010), others are not. Critically, they have the potential to usurp more direct efforts to address social issues. In particular, ‘Health in All Policies’ (HiAP) has received significant national and international interest as a way to address the social determinants of health (Kickbush 2009; Kickbush & Buckett 2010; Sihito et al. 2006). At present, HiAP has been implemented by the South Australian Government and has received critical attention from the European Union and its Member States – for example, Finland and Sweden – as well as Canada (WHO 2011c). HiAP works to place ‘health’ at the forefront of policymaking across government departments through the

use of 'health impact assessments' – that is, attempts to quantify the impact of particular policies on health – creating greater integration between health and other departments. In doing so, developers believe it can encourage a more systematic approach to the social determinants of health (Kickbush & Buckett 2010). The effectiveness of HiAP is yet to be established, with the first evaluation underway (South Australian Government 2013).

To some extent, HiAP draws on recent thinking in social policy around joined-up government. One of the goals of HiAP is to create integration between health and other departments. It resiles from recent thinking, however, in that it places health at the centre of this integration. Principles of joined-up government more broadly seek to establish integration between multiple departments – for instance, meshing health with transport and education, but also education with transport. HiAP, in contrast, seeks only to link health across government. HiAP is also much more prescriptive than other joined-up approaches. It aims to use health impact assessments to influence policy design. If successful, policies that enhance, or are not detrimental to health in its narrowest sense, regardless of broader concerns deriving from research into social determinants, are the ones that will be adopted.

While the effectiveness of HiAP is currently unknown, and there is little knowledge about how it works in practice, its conceptual approach suggests a number of limitations. Firstly, the social determinants of health might well be best served by the type of multi-departmental integration envisaged by more traditional joined-up approaches, rather than by linking health to all other departments. In this sense, thinking behind HiAP represents a continuation of the imperative of health, whereby health is sanctioned as the most important policy issue for governments to address. With complex social policy issues collapsed into matters of health, this type of approach is unlikely to be welcomed by those working in social policy across government and research advocacy.

Secondly, HiAP appears to overlook the complexity of the policy process and the practice of policymakers. Health impact assessments as a means to policy change are part of the 'evidence-based policy' paradigm. While broadly regarded as a useful notion, experts warn that 'evidence-based policy' should not be treated as a panacea, as it does not reflect the realities of policymaking (Matthews 2013). Much of policy decision-making is about the unknown: decisions must frequently be made where little or no evidence exists to inform them. Moreover, in making policy decisions, policymakers need to weigh up a wide range of political, ideological and value-based benefits and costs (Matthews 2013; Taleb 2007). In some instances, a cost to health may be an acceptable outcome for substantial gains in other policy areas. Moreover, the social determinants of health are widely perceived as constituting a wicked policy problem: a complex, indeterminate social factor with no obvious solution (Petticrew et al. 2009).

Hence, both problems and their solutions are unlikely to be perceived in the same way by different departments and sectors. Due to their linear conceptualisation of policy, rational models of policymaking such as HiAP provide a poor basis from which to address wicked policy problems, remaining unable to provide guidance when the views of stakeholders conflict (Hendricks et al. 2013).

Conclusion

Overall, while there is broad agreement on the problem of social disadvantage, those working in social policy – whether in government, research or advocacy – seem less likely to agree about potential solutions. For example, are those working in social policy willing to regard and support health as the primary goal of policy change? Are they willing to support public health interventions such as HiAP, which relies overwhelmingly on an evidence-based policy paradigm? How does the community services sector in particular – with its focus on welfare relief – feel about taking a population-based approach to inequality? Finally, if the answers are no, are they ready to challenge public health on these fronts?

Through critiquing the development of public health as a movement, we have drawn out the points of convergence, as well as the differences, between public health and social policy. We argue that, while much can be gained by the two fields working more closely together, there remain fundamental differences in perspectives and approaches. What may appear to be an easy and natural confluence of interests has the potential to be stymied by disparate conceptual approaches to the problem. In order to maximise the benefits of these sectors working more closely together, these points of difference need to be thought through earlier rather than later.

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