

Ideas, Policy and the Politics of Public Health

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I Introduction

Ideas drive political life and inform the policy making process. To most people this is a rather obvious statement. However, for contemporary political science, the role of ideas has recently been rediscovered, or at least re-emphasized with what some have termed the “ideational turn” in policy studies (Schmidt 2011; Schmidt 2008; Béland and Cox 2010a; Béland 2005; Carstensen 2010). A great deal of work has been done and is on-going to develop a better understanding of how ideas (including scientific evidence) shape and influence public policy. This requires, among other things, clearly defining what does (and what does not) constitute an “idea” and specifying the precise ways in which ideas are linked to policy choices and policy change (Béland and Cox 2010a; Béland 2005; Carstensen 2010; Schmidt 2011). In other disciplines, there are similar or at least linked research endeavours.¹ In a somewhat similar vein, in health care, health policy and public health there is an on-going debate about how and to what extent research (a form of ideas) should inform practice, programs and policy (Greenhalgh and Wieringa 2011).

In this paper, I want to contribute to these discussions and indeed create some linkages between them. Specifically, my goal is to apply some general propositions about the role of ideas in policy making to the specific case of public health. Simply put, my core finding is that two ideas or perhaps it might be better to say “meta-ideas” – science and social justice – are extremely powerful drivers of much of what is said and done in public health research and public health policy. They are, to echo the work of Daniel Béland (Béland and Cox 2010b), ideational processes that construct the problems that get on the policy agenda; shape the assumptions that affect the content of reform; and can and do become discursive weapons in efforts to promote policy change in public health. To support this claim this paper is structured as follows. In the next section, I provide a short overview of the work of Béland and his collaborators on the role of ideas in politics and policy including an extended discussion of what constitutes an “idea”. What follows is a discussion of how, in fact, the two ideas of science and social justice sit at the heart of public health theory and practice. In the fourth section of the paper I refine the argument somewhat by, following Béland and Cox, showing in turn how science and social justice are embedded in public health institutions; how ambiguities and disagreements about these ideas creates political space, and I would insist, the need for politics; and, finally, how different political institutions both constrain and enable the dissemination of there core ideas. The fifth section is an attempt to ground an otherwise theoretical and conceptual discussion and seeks to demonstrate the plausibility of the general argument by applying it to the case of debates around INSITE the safe injection facility in Vancouver, Canada. The paper ends with a brief conclusion that offers some thoughts on further areas of research and reflection.

¹ So, for example, proponents of a “public sociology” are intrigued by the notion of the “public intellectual” and the role that sociological research can and indeed should play in political and social life (Burawoy 2005).

II Ideas and Public Policy

What explains changes in public policy? Why do governments do what they do, and, in some cases, not what at least some citizens would want? Explaining what gets on the agenda of government and what explains policy change is a core preoccupation of political science going back for a century or more. At various times a number of factors have been emphasized as being powerful determinants of policy change. There is neither the need nor space to review the range of theories of the policy making process here.² For our purposes, what matters is that in the last decade or so, political and other social scientists have begun to emphasize (or perhaps more accurately re-emphasize) the role that ideas play in politics and policymaking. Ideas are defined here quite broadly and include varying combinations of discourses, ideologies, and ways of knowing including, of course, science. The core idea is that, as Béland and Cox put it politics (and by extension policy) is “the struggle for power and control among people who are motivated by myriad ideas” and different groups of people emphasize or share different sets of ideas that “inform not only their belief in what they want but what they deem to be appropriate, legitimate and proper.” (Béland and Cox 2010b, 3) Policy debate, on this view, is the result of a tension, if not a clash between different conceptions of what is appropriate or legitimate or proper. The management of this tension or the resolution of the conflict is the stuff of politics.

Defining “Ideas”

But what are ideas anyway? Following Emmerij et. al., Béland and Cox define ideas as “causal beliefs held by individuals or adopted by institutions that influence their attitudes and actions” (Béland and Cox 2010b, 6; Emmerij, Jolly, and Weiss 2005). These ideas can take the form of high profile public discourses and ideologies that are front and centre (e.g., neoliberalism; the occupy movement) or, conversely, lower-profile background assumptions that shape political discourse (e.g., evidence-based policy; small government). Admittedly, this remains quite general and vague. A potentially more accessible approach to defining ideas for policy is provided by Mehta who, drawing on Kingdon and others (Kingdon 2003) suggests that ideas can take the form of policy solutions, problem definitions, or public philosophies or zeitgeist (Mehta 2011).

When they take the form of policy solutions, ideas are propositions of varying degrees of complexity that are advanced by different institutions, groups and individuals. They can be quite broad ideas (or sets of ideas, (e.g., Keynesian stimulus in response to recession) or by quite a bit narrower (e.g., limiting advertising directed at young children). This is by far the most common and straightforward manner in which ideas influence policy. Ideas take the form of policy solutions that are preferred by particular groups or institutions, in some cases with limited attention to the details of the policy problem. So, for the

² For a good introduction to contemporary theories of policymaking and the policy process see, *inter alia*, Moran, Rein and Goodin 2008.

Conservative Party in Canada and especially for Republicans in the United States, cutting taxes and reducing regulation are policy solutions that are routinely advanced in a range of situations to address a wide range of policy problems. In public health, a similar pattern arguably exists insofar as certain policy solutions (e.g., disease screening, action on the social determinants of health) are routinely advanced, in response to a wide range of policy problems. As Mehta suggests (Mehta 2011, 28) the core analytical question for ideas as policy solutions is why some policy ideas become policy (e.g., childhood vaccination) while others do not (e.g., mandatory bicycle helmets). I would also add that “ideas as policy solutions” also gives rise to the analytic question of how it comes to pass that some ideas that were once uncontroversial and enjoyed broad support later become highly contested (e.g., state supported social housing; water fluoridation). Clearly, it is not a question of changing science – the benefits of fluoridation of water are as well understood today as they were a generation ago. Rather it is because the relationship between evidence and policy is not as direct as some might wish to be. Mehta talks of rejecting, “the naïve functional view that the intrinsic worth of the idea solving the problem ... is sufficient for a policy to be adopted” (Mehta 2011, 28). Building on Hall’s early work on the policy impact of ideas (Hall 1989), Mehta notes that to be an effective policy solution an idea must also enjoy a minimum amount of political and administrative viability (Mehta 2011). This is where the work of Kingdon is particularly valuable. Kingdon “three streams” model suggests that for an idea to become policy requires the coming together of three streams, problems, policies and politics (Kingdon 2003; Guldbrandsson and Fossum 2009; Schwartz and Johnson 2010).

Ideas can also enter into the policymaking process as problem definitions. As Mehta observes, a large part of political arguments over policy are exchange over problem definition given that “The way a problem is framed has significant implications for the types of policy solutions that will be seen as desirable” (Mehta 2011, 27) Once a particular problem definition becomes dominant, it excludes policy solutions that are inconsistent with its way of understanding the issues. So, in the public health realm, we are currently experiencing something of a debate over how to properly define the problem of obesity, particularly among children. For some the issue is individual choices about food and exercise whereas for others the issue is much more about broad social and economic structures that encourage certain patterns of food consumption and physical activity (while a minority are not convinced obesity is, in fact, a problem or at least one that governments can or should seek to address). Each of these definitions of the problem is an expression of different sets of ideas about obesity and each encourages and precludes different kinds of policy responses. How policy problems are defined is an on-going focus of research but Mehta makes the case for focusing on a process of “naming, blaming and claiming” (Mehta 2011, 34). Governments are compelled to focus on some issues as opposed to others by a process where the problem is named (e.g., excessive dietary sodium is a risk for high blood pressure); blaming happens, a causal agent is identified (e.g., the food industry); and claims are made that call on governments to act (e.g., regulate sodium content of food). In turn,

argues Mehta, those opposed to the policy will make counterclaims in an attempt to deny the existence of the problem (e.g., challenge the causal link between dietary sodium and hypertension), reject the claim of causal responsibility (e.g., how much sodium is consumed is a matter of personal choice) or shift the emphasis to other causes or remedies (e.g., voluntary codes of industry conduct).

Finally, following the framework suggested by Mehta, ideas can become an important part of the policymaking process by virtue of the fact that they serve as public philosophies or as a zeitgeist. On this account, a public philosophy is an idea about how to understand the purpose of government generally or a particular policy that flows from a certain set of assumptions about the relationship between state and society, between government and the governed, including markets (Mehta 2011, 40). The zeitgeist in a somewhat broader set of assumptions that is widely shared and generally not open to criticism. While in Mehta's formulation the zeitgeist is roughly equivalent to the national mood, I suggest that the more interesting part of the concept is the notion that the ideas are widely shared and rarely challenged. In this sense, in addition to the broader societal zeitgeist there are arguably somewhat narrower but nevertheless powerful versions operative within specific policy domains. So for example, until recently, that markets and individuals within markets behaved rationally was a powerful shared assumption in economics and, by extension, in much of economic policy.³ As I will argue below, I believe that public health is animated by a similar zeitgeist, that is to say a set of widely shared assumptions that are either not open to criticism or such criticism is limited to a small minority.

Defining "Institutions"

Of course, this approach to ideas begs the question of what constitutes an "institution" which, as should be clear by now, is used here to mean much more than government institutions (e.g., parliament, crown corporations, the courts). In fact, the approach being advocated here is both very broad and quite specific. It is very broad because the work of Béland and Cox and indeed the work of a whole generation of scholars in political science and other social sciences adopts a very broad definition of institutions. So, for example, March and Olsen, arguably among the most influential contributors to the contemporary study of institutions, suggest that:

An institution is a relatively enduring collection of rules and organized practices, embedded in structures of meaning and resources that are relatively invariant in the face of turnover of individuals and relatively resilient to the idiosyncratic preferences and expectations of individuals and changing external circumstances (March and Olsen 2008, 3).

This very broad definition of an institution is both very common in contemporary

³ What has come to be known as "behavioural economics" offers a quite different account of individual and market behaviour (Wilkinson 2007).

political science and, arguably, not all that helpful absent an application to a specific case of policy change. So, for the purposes of this paper I propose to move quickly to specify that when analysing public health institutions we should focus on both the formal structures of government (e.g., government departments or agencies like the Public Health Agency of Canada or the U.S. Food and Drug Administration); civil society organizations both large (e.g., the American Public Health Association) and small (e.g., the Portland Hotel Society one of the key actors in the debate over a safe injection site in Vancouver); and the rules and organized practices that structure the work of the public health enterprise (e.g., immunization; the International Health Regulations; harm reduction).

Ideas and Public Policy

To summarize the argument so far, ideas are a powerful driver of policy because they serve, *inter alia*, as policy solutions, as problem definitions, and most broadly, as public philosophies or as part of the *zeitgeist*.

It is possible to further specify the role that ideas play in the policy making process by returning to the work of Béland and Cox. They argue that ideas are powerful drivers of policy change because:

- ideas embedded in the design of institutions;
- ambiguity and disagreement about ideas is the source of political debate;
- political institutions both constrain and enable the dissemination of core ideas.

What follows is a brief explanation of each of these propositions that will be explored in more detail below with reference to public health in general and to INSITE in particular.

In making the case that ideas are embedded in the design of institutions, Béland and Cox argue that, in fact, ideas are the foundations of social, political and economic institutions (Béland and Cox 2010b, 8). They write,

As ideas give rise to people's actions and as these actions form routines, the results are social institutions, the founding ideas are reproduced. The ideas are enshrined in institutions. As people interact with institutions, the founding ideas are reproduced (Béland and Cox 2010b, 9).

They go on to suggest that institutions also nurture people's identities and help them to define their values that in turn shape beliefs and interests.

But of course, ideas are by their vary nature ambiguous or, at the very least their meaning is often contested. Following Cox and Béland, it is this ambiguity, purposefully exploited by some, that opens the space for political debate as people seek to promote policy decisions that reflect their preferred interpretation of a given idea or set of ideas (Béland and Cox 2010b, 9). In their words:

The ideas upon which institutions are formed are also subject to discursive revision as actors reinterpret and debate the meanings of the ideas upon which existing institutions are constructed. The ideas that define institutions, as well as the ideas shared by political actors, are in flux, often at odds, and malleable (Béland and Cox 2010b, 10).

Ideas, on this account, afford more power to certain actors and less to others. To be able to assert and control the definition of a key idea is a source of political power. To the extent that other actors are successful in contesting the prevailing definition of a given idea, this becomes a source of political debate if not political conflict.

Finally, the suggestion that political institutions both constrain and enable the dissemination of core ideas is a critical insight (Béland and Cox 2010b, 15). Political institutions are a subset of the broader universe of institutions and include, for the purposes of this paper, both formal government institutions (e.g., parliament, Cabinet, executive government more generally) as well as more purposefully political organizations (e.g., political parties, organized interests). The idea here is that each of these institutions acting alone and in concert, can be a powerful constraint on the dissemination, visibility, and impact of ideas be they policy solutions, problem definitions or elements of the zeitgeist. Conversely, these same institutions can also (and perhaps simultaneously) promote certain ideas over others.

III Public Health, Social Justice and Science

Ideas have the capacity to drive policy change and influence the policy agenda. They serve as policy solutions, problem definitions, and serve as public philosophies large and small. So what does any of this have to do with public health much less INSITE? Simply put, these general claims with respect to ideas and public policy apply to the specific case of public health. Thus, my goal in the balance of this paper is to show how two ideas – social justice and science – lie at the heart of the public health enterprise (Tilson and Berkowitz 2006) and substantiate this general claim with specific reference to INSITE.

A. From Virchow to Marmot by way of Canada: Social Justice at the Heart of the Public Health Enterprise

In 1919 Charles Hastings, the Medical Officer of Health for the City of Toronto served as President of the American Public Health Association. In his presidential address Hastings made the case for an expansive, social justice agenda for public

health. As he put it:

Every nation that permits people to remain under the fetters of preventable disease, and permits social conditions to exist that make it impossible for them to be properly fed, clothed and housed, so as to maintain a high degree of resistance and physical fitness, and that endorses a wage that does not afford sufficient revenue for the home, a revenue that will make it possible for the development of a sound mind and body, is trampling a primary principle of democracy under its feet. (Hastings 1919: p. 4)

However, the social justice roots of the public health enterprise were evident well before Hastings' address. Arguably they go back to the very beginnings of public health and social medicine in the mid-19th century in England and Germany. For example, as almost every student of public health is taught, Rudolf Carl Virchow was a German physician and pathologist who did much to carve out what came to be known as social medicine, one of the tributary disciplines to contemporary public health. In his famous "Report on the Typhus Epidemic in Upper Silesia, his recommendations went far beyond a strictly medical response and outlined a program of social reconstruction including universal education, higher wages, and full employment (Virchow 2006; Taylor and Rieger 1985). That role of a social justice agenda in public health has waxed and waned. In Britain, in the United States and in Canada (and perhaps in other countries as well), the earliest manifestations of what we now know as public health were often linked to an expansive if not a radical agenda of social, political and economic change. However, this agenda was eventually overtaken if not eclipsed by an attempt to ground public health in science and reap the benefits of the technological and engineering advances of the late 19th and early 20th century notably (but not limited to) vaccination and sanitation (Porter 1999; MacDougall 1990; Irvine et al. 2006; Porter 1994).

Despite the ascendancy of a "public health as science" for most of the 20th century, social medicine never really disappeared, especially in Europe, (Pemberton 2002; Porter 1999). Nevertheless, the social justice ethos of the public health enterprise remained in the shadows until the 1960s when, perhaps reflecting the tenor of the times, a "new public health" came to the fore, more in tune with the social justice roots of public health (Irvine et al. 2006; Fairchild et al. 2010). This "new public health" emphasized much more than the fight against communicable disease and focussed on health promotion, disease prevention and, indeed, a social policy agenda (Bernier 2009; Petersen and Lupton 1997). This advent of this new public health is particularly evident in Canada although it manifested itself in Europe and in the work of the World Health Organization (Kickbusch 2003), and in academic circles. So, once again, as almost all students of public health are taught, a document released in 1974 by the Canadian federal Minister of Health, Marc Lalonde, is symbolic of the shift in emphasis in the new public health. The "Lalonde

Report” as it quickly became known, introduced the concept of the “health field” and is one of the founding documents of health promotion a distinct and increasingly important part of the public health enterprise (Lalonde 1974). What is remarkable about the Report is that it is a government document that asserts that the importance of addressing the environmental and social determinants of health and goes on to indicate that the goal of the Government of Canada would continue to be, “not only to add years to our life but life to our years, so that all can enjoy the opportunities offered by increased economic and social justice” (Lalonde 1974, 6). The Lalonde Report gave rise to the “Ottawa Charter”, an international agreement initiated by the World Health Organization and launched at a conference in Ottawa in November 1986 (Potvin and Jones 2011; Hancock 2011). The Ottawa Charter states that health “is created and lived by people within the settings of their everyday life; where they learn, work, play and love” (World Health Organization 1986) and aims to combine a social determinants approach with a commitment to individual and community empowerment.

In a sense, the place of social justice in the public health enterprise has come full circle.⁴ As Krieger and Birn put it, “Social justice is the foundation of public health” (Krieger and Birn 1998, 1603) A social justice agenda, often subsumed under the heading of the “social determinants of health” is now a highly visible part of the public health agenda even if this visibility varies by country and enthusiasm for a social justice agenda is unevenly shared among different actors with public health and beyond.

The Essentially Contested Nature of Social Justice

It is one thing to say that social justice sits at the health of the public health enterprise or as Beauchamp has put it, “The historic dream of public health ... is a dream of social justice” (Beauchamp 1976, 6). It is quite another to specify what is meant by “social justice”. For the overwhelming tendency in accounts of the role of social justice in public health is to simply assume or assert a shared meaning of the concept. There is any number of discussions of the place of justice or social justice in the public health enterprise but only rarely is the term defined and even less common is the acknowledgement of the fact that there are multiple conceptions of justice even after appending the term “social”. Recent work by scholars has begun to rectify this imbalance⁵ but this has had only a limited impact on the day-to-day references by public health professionals to social justice.

So, for example, Krieger and Birn, having asserted that social justice is the foundation of public health, only go so far as to link it to the basic idea that public

⁴ Other indicators of a resurgence of a social justice orientation in public health are the WHO Alma-Ata declaration of 1978, the Black (1980) and Acheson (1998) reports in the United Kingdom, the WHO Healthy Cities Project, and the Jakarta Conference on Health Promotion in 1986 (Irvine et al. 2006)

⁵ For sophisticated discussions of the links between social justice and public health see, *inter alia*, Powers and Faden 2008; Venkatapuram 2011; Anand, Peter, and Sen 2004; Segall 2009.

health is very much a matter of collective action and recommend that we embrace the concept of “collective health” used commonly in Latin America (Krieger and Birn 1998). Similarly, while Gostin and Powers hint at the possibility of disagreement about the nature of justice, contrasting their interventionist and egalitarian approach with others, “Our account of social justice is interventionist, not passive or market-driven”, no where is the concept clearly defined (Gostin and Powers 2006, 1056). Nancy Edwards, for her part, invites members of the public health community to revisit their social justice roots but does not specify what social justice entails but does offer examples which suggest that it is about addressing inequality and disadvantage and pursuing public health interventions for the: “benefit those who are experiencing the dark side of material and social disadvantage” (Edwards 2009).

On balance, it would appear that this focus on inequality and disadvantage is at the heart of the public health conception of social justice. As Buchanan has argued, a prominent position in public health (I would argue in fact it is “the” prominent position) is “founded on an egalitarian conception of justice” and is defined by “an opposition to inequality and thus demands an equitable distribution of collective goods, institutional resources and life opportunities” (Buchanan 2007, 4). Very often this resolute focus on inequality is based on the simple but profound observation that inequality is a powerful predictor of health and health status. A plethora of studies have shown that there is a “social gradient of health”. Not only do the poorest around the world have the worst health, within countries the lower an individual’s socioeconomic position the worse their health. Note that it is not just poverty that contributes to poor health it is inequality. Even in the richest countries, inequality has negative health outcomes (Wilkinson and Pickett 2010). On this account, if socioeconomic inequality is a powerful predictor of poor health and we wish to improve the health status of all, it is imperative to address inequality. Moreover, what is often implicit in a lot of public health analysis is the claim that the best and indeed perhaps the only way to address inequality is by redistribution. Indeed, the WHO Commission on the Social Determinants of Health made a number of recommendations that called for a major redistribution of wealth if only by retaining an expansive welfare state capable of pursuing a program of early child development, public education, employment creation and improvements to working conditions, health system reform, the creation of healthy living places, gender equity, and market regulation (Commission on the Social Determinants of Health 2008; M. G. Marmot 2012).

While one may be sympathetic to an egalitarian conception of justice, and even more so on the argument that inequality leads to poor health, it is imperative to take into account the simple reality that there are other conceptions of justice. Among political theorists and indeed among citizens there is no consensus of what constitutes social justice. We disagree on the appropriate way to distribute resources. Some would argue that wealth and other resources be distributed more or less equally -- to each person an equal share (Cohen 2008). Others would focus on need -- to each according to need (Rawls 1999). Still others would argue that

personal responsibility and effort be a determining factor -- to each according to effort (Nozick 1977). Each of these conceptions of justice has its defenders and, in some countries, they can help us distinguish one political party from another. Which brings me to the core issue – disagreements about the very nature of justice are inherently political and the public health enterprise is routinely and systematically blind to the fact that there is not one but many conceptions of justice. As a result, policy disagreements (e.g., government investments in social housing) are rooted, at least to some extent, in rather deep disagreements on what constitutes justice and the role of government in furthering the cause of justice.

B. "We are all scientists": the public health commitment to science

Not all who work in public health necessarily share a deep commitment to an egalitarian conception of social justice. Some, trained to do hard-core basic science, may have no strong views on social justice or its role in the public health enterprise. This point of view is quite understandable insofar as, at its core, public health sees itself as a scientific discipline or, perhaps more accurately, as an enterprise built on several scientific disciplines (Patel and Rushefsky 2005 Chapter 5).

That science lies at the heart of the public health enterprise is something of an axiomatic claim. That public health is a science-based exercise is clear enough insofar as in the training of public health professionals, even more common references than Virchow or Lalonde is the telling and retelling of the story of John Snow and the Broad Street pump. In the face of a cholera epidemic in London in 1854, Snow and colleagues talked to local residents and he was able to trace the source of the outbreak to the public water pump on what was then Broad Street in central London. His research was enough to convince the local council to disable the pump by removing its handle. The incidence of cholera quickly abated although not only as a result of removing the pump handle. Snow later able to confirm his hypothesis that cholera spread as a result of contamination of the water supply (Vinten-Johansen et al. 2003; Patel and Rushefsky 2005 Chapter 5). His careful study of the pattern of disease and tabulation of detailed statistics on the incidence of cholera were the beginning of the scientific discipline of epidemiology that is the core discipline of modern public health.

While not all public health professionals are trained as epidemiologists most have some form of scientific training whether it be in the allied discipline of biostatistics, in environmental health, or in medicine. And the medical orientation of public health should not be underestimated given the simple fact that at the head of most public health organisations, at least in North America, one finds a physician trained in some combination of public health, community medicine, or social medicine.

The scientific basis of public health is considered by many to be critically important to the overall legitimacy of the public health enterprise. In fact, the scientific orientation of public health often overshadows the social justice agenda.

As Potvin and Jones observe, "[...] the normative nature of public health is often masked by the highly scientific content of the field" (Potvin and Jones 2011).

On this account, the ability of public health to directly influence individual behaviour (e.g., stop smoking campaigns; public awareness of obesity) or otherwise constrain behaviour by means of government action (e.g., smoking bans; taxation of sugar-laden soft drinks) is inextricably linked to its status as a science. The assumption seems to be that the situational power of public health lies in its ability to make science-based arguments given the legitimacy that governments and indeed the general public give to science.

It is for this reason, among others, that many in public health are keen to limit how, when, and to what extent the scientific findings of epidemiologists and other public health disciplines are linked to the policy making process. In fact, at least one public health journal, *Epidemiology*, has a policy of discouraging authors from making policy recommendations as part of articles that report scientific findings (Teret 2001; Samet 2000). The originator of that editorial position, Kenneth Rothman, in an editorial in another public health journal argued that, having focused on a research area, scientists should ignore policy questions to persevere in pursuit of their objective, which is knowledge. In his view, the time for a scientist to be a political and social mover is after hours (Rothman and Poole 1985).

Needless to say, this position is not shared by those in the public health community with a more explicit orientation to social justice or at least social change (Krieger 1999; Weed and Mink 2002; Weed and McKeown 2003). For those who see public health in social justice terms, it would be inappropriate if not simply wrong to limit public health research to laying out the science (Chapman 2004; Bassett 2011). Nevertheless, the social justice perspective assumes that the public health enterprise is firmly grounded in science and the scientific method. There is a strong consensus that the ability to influence policy and program decisions lies in the fact that public health is based on science (Weed and Mink 2002). On this view, public health becomes an enterprise where science and social justice come together to address population health.

IV Ideas in Action: INSITE and the WHO Commission on the Social Determinants of Health

While it is one thing to show that, in general terms, science and social justice are the core ideas that drive the public health enterprise, in this paper I want to sketch the practical implications of this general claim with reference to two specific, and relatively high profile public health initiatives of the recent past. The first is the WHO Commission on the Social Determinants of Health (CSDH) chaired by Sir Michael Marmot. The second is INSITE, a safe injection facility in Vancouver. Each in their own way, they demonstrate both the central place of science and social justice. However, to push this idea even further, in the balance of this paper I use

these two examples to show in turn how science and social justice are embedded in public health institutions; how ambiguities and disagreements about these ideas creates political space; and, finally, how political institutions both constrain and enable the dissemination of there core ideas.

The Commission on Social Determinants of Health (CSDH) was an initiative of the World Health Organization and was launched in 2005. The CSDH was mandated to gather, review and synthesize evidence on what needs to be done to reduce health inequalities within and between countries. In completing its work, the CSDH created a global network of policy makers, researchers and civil society organizations with a view of not just writing a report but one that would provide support in tackling the social causes of poor health and avoidable health inequalities. It issued a lengthy report in 2008 (Commission on the Social Determinants of Health 2008). The report in turn generated in turn considerable scholarly debate and discussion (Irwin et al. 2006; Muntaner et al. 2009; Michael Marmot and Bell 2009; Bates, Hankivsky, and Springer 2009).

To the extent that the CSDH is a global imitative, INSITE is a very local one. INSITE is a small storefront facility located in the Downtown East Side (DES) of Vancouver. INSITE offers injection drug users a safe, clean medically supervised place where they can use drugs. The facility was established as part of a comprehensive response to an alarming increase in the drug-related deaths and an alarming increasing in the rates of HIV in the DES beginning in the early 1990s due in part to needle sharing. To be able to operate, in 2003, the Government of Canada agreed to exempt the Vancouver Coastal Health Authority from the *Controlled Drugs and Substances Act*, to allow for a medically supervised safe injection facility. INSITE was granted a three-year exemption linked to a rigorous evaluation of what was styled as a pilot project. However, less than 18 months later a Conservative government was elected and later announced a renewal of the exemption only until December 31, 2007 (Dooling and Rachlis 2010). Faced with the threat of closure, the proponents of INSITE launched a legal challenge that eventually landed before the Supreme Court of Canada. In September 2012, the Court ruled that the individual rights of drug users as protected by the Canadian Charter of Rights and Freedoms required the Minister to exempt the facility from federal drug control legislation (Dooling and Rachlis 2010; Wells 2011)

A. *Science and social justice are embedded in public health institutions*

Science

The CSDH was very much an evidence-drive exercise and much of its work was driven by a series of 'Knowledge networks' made up of academics and practitioners from around the world, who collected evidence on policies and interventions to improve health and reduce health inequities (Commission on the Social Determinants of Health 2008, 42). These knowledge networks were organized thematically and dealt with a number of critical issues that arise of a social determinants perspective on health including the role of early child

development, employment conditions, globalization, and women and gender equity. These networks fed into the Commission final report which, is presented as an empirical demonstration of the imperative of addressing the broader social and economic drivers of health and in particular health inequality (Commission on the Social Determinants of Health 2008, 43).

Presented in this way, the CSDH is similar to other commissions of inquiry whose reports are written on the basis of commissioned research. What makes the CSDH somewhat different, however, is the explicit efforts made to buttress the recommendations with extensive references to scientific evidence. In the summary statement of the Commissions recommendations early on in the Report, each is presented with “evidence for action” and the idea is that the weight of evidence is so compelling that action must surely follow (Commission on the Social Determinants of Health 2008, 3–23). In this regard, the CSDH is reflecting the contemporary push for evidence-based policy-making that argues that good policy flows from good evidence. Policy choices based on little or no scientific evidence are deemed to be nothing more than “politics” where politics is used to refer to decisions that are based on ideology or partisan preferences.⁶

The role of scientific evidence in INSITE is also very clear. In fact, the facility was established as a research project that was initially funded by Health Canada. When the federal government became actively opposed to the facility, research (and operating) funding came from the provincial government via the local regional healthy authority – Vancouver Coastal Health. From almost the very beginning the defenders of INSITE have emphasized the extensive research demonstrating that the facility works very well. Thus, the research on INSITE has appeared in the major scholarly journals devoted to the study of addictions and drug use, as well as in some of the most prestigious and/or high impact scholarly journals devoted to health policy and practice. In the first five years of the scientific evaluation, over 30 studies were published in peer-reviewed journals demonstrating that the facility was associated with a range of health and social benefits and not associated with adverse effects (British Columbia Centre for Excellence in HIV/AIDS 2009). Like the CSDH, the proponents of INSITE (and other safe injection facilities) believe that this evidence base should be sufficient to compel governments to support them (Debeck and Kerr 2010). On this view, one of the strongest arguments in favour of harm reduction generally and a safe injection site in particular, is the evidence base.

Social Justice

The fact that ideas are embedded in institutions is well demonstrated by the place of social justice in the work of the Commission on the Social Determinants of Health. The Commission’s final report, *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health*, offers an evidence-based call

⁶ This is an oft-repeated view in public health (and in other science-dominated fields). Public health commentary on INSITE is an excellent example of this in a Canadian context. See *inter alia* Debeck and Kerr 2010 and Hwang 2007.

for action that is firmly rooted in a social justice approach. Thus, the first sentence of the report states flatly “social justice is a matter of life and death” and goes on to argue:

Poor and unequal living conditions are, in their turn, the consequence of deeper structural conditions that together fashion the way societies are organized – poor social policies and programmes, unfair economic arrangements, and bad politics. [...] Putting these inequities right is a matter of social justice.” (Commission on the Social Determinants of Health 2008, 1 and 26)

The CSDH Report returns again and again to theme of social justice oftentimes by means of a repeated focus on health equity. That said, precisely what social justice and health equity actually mean is not all that clear. In a subsequent paper on the work of the Commission, Marmot et. al. observe that: “manifest injustices exist where reasonable means could be deployed to alleviate disproportionate ill health or prevent mortality” (Venkatapuram, Bell, and Marmot 2010) In this sense Marmot and the Commission echo the classic definition of health inequality developed by Whitehead and Dahlgren: “Health inequalities that are avoidable, unnecessary, and unfair are unjust” (Whitehead 1992).

The place of social justice in the rationale and operations of INSITE is somewhat more difficult to specify. As an explicit harm reduction initiative, INSITE is concerned first and foremost with reducing the illness and early deaths that are the direct result of illegal drug use. The focus is on those who inject drugs such as heroin and the associated risk of overdose, illness and exposure to HIV. The underlying conception of social justice is egalitarian insofar as it asserts the equality of all citizens and the duty to provide assistance to all, even when they are engaging in what is an illegal act. Like the CSDH, the proponents of harm reduction in general, and INSITE in particular, see the death and illness associated with illegal drug use as avoidable and for which there are reasonable means to address the problem. However, theirs may be less a concern with social justice per se and much more an approach rooted in a notion of equal citizenship.

As Jane Jenson has observed, there is a longstanding concern in public health with marginalized populations. After a detailed analysis of the rationale for public health interventions in 19th century Britain, Jenson concludes that the decision to proceed with a given public health measure is shaped by the prevailing citizenship regime and who is, and who is not, considered a full citizen deserving of public health protection. In effect, on this view, public health is “shaped by broader societal debates about the role of the state and its responsibilities vis-à-vis citizens” (Jenson 2008, 535) She concludes her argument with a short reference to INSITE and hints that the disagreement may turn on whether persons addicted to drugs are, in fact, full citizens and whether the state therefore has an obligation to take action to meet their needs. She references the decision of the B.C. Supreme Court that ruled that INSITE should remain open so as to protect the Charter rights of those

using the facility and telling citizens on of the users of INSITE: “This says addicts are Canadian citizens too. The most conservative judge in B.C. got that we are real people and we have the right to have a normal life” (Jenson 2008, 552)

B. Politics: Managing Ambiguities and Disagreements about Ideas

Science

When the Supreme Court of Canada finally ruled on the conflict over INSITE, supporters of the facility argued, among other things, that the decision was an example of evidence trumping politics. They celebrated the fact that the Court acknowledged the scientific evidence demonstrating the benefits of INSITE (Moore 2011). However, in the months and years before and after the opening of INSITE, there was something of a manufactured debate about the evidence in favour of harm reduction. Disagreements about the science underlying harm reduction created, to return to the phrase of Béland and Cox, space for political debate.

After they were elected in 2005, the Conservative government made its opposition to INSITE very clear. Their initial strategy included an attempt to make an evidence-based argument against INSITE. In doing so they deployed many of the classic techniques designed to shed doubt on scientific findings (McGarity and Wagner 2008).

For example, one strategy was to argue that there was insufficient research. Early on, there was some truth to this argument. Before INSITE opened and the associated research program was launched, the evidence in favour of safe injection sites was relatively scarce. Other similar facilities had been opened in Europe but had not been rigorously studied. As a result, while there is now a strong body of scientific evidence to support safe injection sites, such was not the case before INSITE opened (Fafard, 2012). However, even as the body of research showing the benefits of INSITE began to accumulate, the federal government continued to argue that there was insufficient evidence. When the then federal Minister of Health, Tony Clement announced that he was deferring a decision to renew the exemption accorded to INSITE under federal drug legislation, he argued that there were unanswered questions associated with safe injection sites. In particular he said it was not clear that supervised injection facilities played a role in lowering drug use overall and reducing rates of addiction. This question was somewhat misleading, however, insofar as INSITE and similar facilities are not meant to address these objectives and focus much more narrowly on reducing harm to the drug users who choose to use the facility (Dooling and Rachlis 2010). In a similar vein, in an address to the Canadian Medical Association in August 2007 the federal Minister of Health said, “There has been more research done, and some of it has been questioning of the research that has already taken place and questioning of the methodology of those associated with INSITE” (Solomon 2007).

The federal minister subsequently convened an expert advisory committee

to examine existing research on supervised injection facilities. In April 2008, the expert advisory committee issued its report and the majority of its conclusions were positive. In trying to make the most effective use of the report, the government chose to highlight the committee's conclusion that there was no evidence that INSITE had influenced community-wide drug use or relapse even though, this is not one of the objectives of the facility.

Another well-documented strategy for contesting scientific evidence is to commission competing research. In this case, the Royal Canadian Mounted Police (RCMP) commissioned research in the hope of obtaining arguments that could be used to oppose INSITE (Geddes 2010; G. Mason 2008). After the first commission report concluded that INSITE was worthy of continued support (Dooling and Rachlis 2010) the RCMP commissioned two others that alleged there were serious methodological failings with the research supporting INSITE (Manghan 2007; Davies 2007). However, the validity of these studies has subsequently been put into question. Both studies were not peer-reviewed and detailed analysis revealed that the authors all but ignored contradictory evidence and made largely unsubstantiated claims that harm reduction led to a neglect or more traditional treatment programs (Dooling and Rachlis 2010; Hathaway and Tousaw 2008). Nevertheless, both the RCMP and the Conservative Government repeatedly referred to these studies although it has recently been reported that the police are keen to distance themselves from these studies (Geddes 2010). And even after the Government of Canada stopped framing its opposition to INSITE as a matter of science, others continued to do so. REAL Women of Canada and the Drug Prevention Network of Canada commissioned Drug Free Australia to produce a report that called into question some of the research generated showing the merits of INSITE (Montaner 2011).

The broader issue is that the decision to proceed with INSITE and safe injection facilities more generally was not and indeed cannot be based solely on the basis of the accumulated scientific evidence. There will always be disagreement about the science underlying harm reduction – it is the nature of the scientific method to continually seek to review existing research. Moreover it is in the nature of political debate to continue to try and manipulate ideas to advance preferences. As Béland and Cox argued, people seek to promote policy decisions that reflect their preferred interpretation of a given idea or set of ideas. In this case, even after the debate around harm reduction as such has more or less subsided, opponents of INSITE continue to make arguments, not so much about the benefits to those who use the facility but about the broader canvas of drug addiction more generally and their preferred emphasis on prevention. The debate also continues because science alone cannot resolve how we deal with the issues arising from illegal drug use.

Social Justice

While the concept of social justice lies at the heart of the Report of the WHO Commission on the Social Determinants of Health, there is some ambiguity in what

the concept actually means. Precisely because the CSDH deployed a health-specific definition of health inequality (Whitehead 1992) how this is linked to broader and philosophical conceptions of social justice is not clear. Nor is it entirely clear what the approach to social justice used in the CSDH report has for practical politics. For as long as the argument remains a general one – we favour social justice – few would disagree. What matters is when this broad, general goal is translated into concrete policy and program choices. So, for example, when the Report emphasizes the critical importance of early childhood development, I expect few would disagree on the importance of ensuring that all children get a good start in life. Where the debate begins, however, is on the best ways to achieve this. Is the goal simply improving the care provided to young children were at greatest risk or is the goal more ambitious, ensuring equitable access to care? Similarly, does achieving the vision of early childhood development set out by the Commission involve some form of government-supported child care or is the objective a more modest one of providing support to families to allow them to better support children? Answers to these and similar questions reveal what the Commission references to “social justice” really mean. This being said, there is a strongly egalitarian in the way in which the Commission Report talks about social justice.

C. Political Institutions and the Dissemination of Ideas

Science and Social Justice

The earlier discussion of INSITE demonstrated the power of a political party and of a government, in this case the a Conservative government, to limit the impact of science, in this case the science underlying harm reduction and safe injection sites. However the INSITE case demonstrates how other institutions, broadly defined, have an impact on the place that science holds in policy making.

Consider for example, the implications of federalism.⁷ As I have argued elsewhere (Fafard 2012), the fact that INSITE was launched was not the result of a steady accumulation of scientific evidence. On the contrary, INSITE is the result of a process of coalition building and political mobilization at the local level. Critical to the launch of the facility was the support of the City of Vancouver, the local regional health authority, and the Government of British Columbia. And once a critical mass of support had been gained the proponents were able to bring the Government of Canada onside (Kerr, MacPherson, and Wood 2008; Campbell, Boyd, and Culbert 2009). In fact, the launch of INSITE was facilitated by an umbrella agreement between the federal government and the province – the Vancouver Agreement

⁷ While I discuss the impact of formal political institutions in this paper, the success of INSITE is also due to the ways in which other institutions, broadly defined, aided and abetted both the science and social justice arguments that drive the INSITE project. I am thinking, for example, of harm reduction as a social movement (Tammi and Hurme 2007) and the role of community organisations such as the Portland Hotel Society and the Vancouver Area Network of Drug Users (Campbell, Boyd, and Culbert 2009; Fafard 2012).

(Mason 2007; Leo 2006). Conversely, it was a lack of intergovernmental agreement between British Columbia and Canada after the election of 2005 that led to the future of INSITE going all the way to the Supreme Court of Canada with several provincial governments as intervenors. They were looking to defend the principle that health care is a matter of provincial jurisdiction and should not be subject to constraint by the federal power over the criminal law. The arguments around interjurisdictional immunity brought by the Government of British Columbia and others, did not, in the end, carry much weight with the Supreme Court (Kim 2012; Wells 2011). However, the fact that they prevailed in B.C. courts suggests that the success or failure of the INSITE project was about scientific evidence yes, but evidence channelled and constrained by the simple fact that Canada is a federation and proponents of science-based arguments need to convince two or more orders of government and subsequently retain this support.

In the case of the Commission on the Social Determinants of Health, it would be hard to overstate the effect of the Commission on the status of the very notion of the social determinants of health. While the CSDH built on an extensive body of scholarly work on the social and economic determinants of health, the fact that a United Nations organisation, the World Health Organization, was willing to not only endorse the notion but also popularize it was a significant milestone. As alluded to above, the work of the Commission led to a similar initiatives in Britain (M. Marmot 2010) and later for all of Europe.⁸ The CSDH Report also set the state for a follow-up global conference in Brazil in October 2011 that adopted the Rio Political Declaration on Social Determinants of Health (World Health Organization 2011). There is also an effort underway to convince the World Health Organization to adopt a Framework Convention on Global Health (Gostin 2007).

However, the profile and impact of the original Commission is also quite mixed. In some countries, for example, Brazil (Gomes Temporao 2009) and the United Kingdom (Brown 2009), the Commission enjoyed a high profile and arguably had some influence on government more generally. Moreover, there is some evidence that the work of the Commission has influenced the ways in which health policy is discussed at the subnational level building on the pre-existing interest in the concept that health status is a function of social and economic factors. In other cases, such as Canada and the United States, the work of the Commission went largely unnoticed outside of the public health community. And even in the United Kingdom, the current government led by David Cameron does not share the interest or the enthusiasm of the previous Labour government for the notion of the social determinants of health. Indeed, this is to be expected. As Jenson puts it, “[...] the structure of the citizenship regime not only shapes choices about public health interventions but also can limit the implementation of solid medical knowledge is as important for the present as for the past” (Jenson 2008, 551).

⁸ The WHO Regional Office for Europe has commissioned a regional review of the health divide and inequalities in health from July 2010 to 2012 in order to inform the new health policy for the Region (European Social Determinants and Health Divide Review 2010).

V. Conclusion

As children we are taught that sticks and stones may break our bones but words will never hurt us. The realities of hate speech and the power of words to incite violence and hatred suggest that this is not a lesson we may want to pass on to our children. But not only can words be the source of harm, they are also powerful agents of change. Words, or as I have tried to argue in this paper, ideas, act as powerful drivers of policy change. The central claim being advanced here is that this is particularly true in the realm of public health. Two ideas, which are perhaps better understood as meta-ideas, drive the public health enterprise – science and social justice.

But to argue that ideas are a critical determinant of public policy and policy change requires a theory of the policy process. Thus, in the first part of this paper I provided a short overview of the work of Daniel Béland and his collaborators on the role of ideas in politics and policy. This generated a set of three propositions: ideas embedded in the design of institutions; ambiguity and disagreement about ideas is the source of political debate; and, political institutions both constrain and enable the dissemination of core ideas. After making the argument that science and social justice are at the core of public health the final section of this paper sought to demonstrate this claim by considering how each of the theoretical propositions was manifest in two high profile public health initiatives of the last decade: INSITE the safe injection facility in Vancouver and the WHO Commission on the Social Determinants of Health.

Overall, the place of science in public health is by far the stronger of the two meta-ideas. Science is deeply embedded in the major institutions of public health and is a key driver of both the policy dynamics of INSITE as well as the work of the CSDH. However, the science of harm reduction was deeply contested by both police and, latterly the Government of Canada. This generated considerable political debate that was (temporarily) put to rest by the decision of the Supreme Court of Canada. Moreover, INSITE offers an excellent example of how variety of political institutions notably federalism and the party system shape how science is used in policy. If nothing else, the debate over harm reduction that was sparked by INSITE is a powerful reminder to the public health enterprise that there is never a single decision maker (Murphy and Fafard 2011). While the science that underpins the contemporary focus on the social determinants of health is less contested, it remains at the core of the work of the CDSH consistent with the broader public health ethos that policy should be evidence-based. However powerful a WHO Commission might be in some countries, it is clear that the policy agenda proposed has had considerably less impact in others, and in the case of the United Kingdom, shifted dramatically with a change in government.

The ability of the idea of social justice to drive policy change is arguably less straightforward. In the case of INSITE the place of social justice is somewhat

ambiguous and the non-science arguments were as much about juxtaposing “health” and “crime” agendas and trying to situate users of the facility as addicts with health needs as opposed to illegal drug users who were less than full citizens. In the case of the CSDH, while social justice figured prominently in the Commission’s Report, it is not clear precisely what the term does and does not mean. In fact, this ambiguity may be deliberate. A loosely defined concept of social justice is more likely to attract a wider range of political viewpoints creating the potential for a more powerful movement for change.

The approach outlined here needs to be further developed in a number of different ways. First, the framework of Béland and Cox and their collaborators can be potentially enhanced by the work of Schmidt and others on what has come to be known as discursive institutionalism (Schmidt 2008; Schmidt 2010; Fischer 2003). Similarly, the work of Yanow on interpretive policy analysis could well offer additional insights into how to best understand the motive power of ideas in public health (Yanow 2009; Yanow 2000). Similarly, additional case studies are required to fully substantiate the central claims being made here. For example, powerful economic actors do not figure prominently in the story of INSITE or the work of the CSDH. Their role is, at best, indirect. Yet the contemporary public health agenda as suggested by the concepts of the social determinants of health and health-in-all policies is vast and complex. The lessons learned from a half-century of efforts to regulate tobacco use is that when powerful economic actors feel that their interests are threatened by government public health efforts they will fight back, hard. Something similar is already occurring as public health officials look to regulate the sodium content of food and the availability of sugary drinks. Just as ‘bit tobacco’ resisted and actively opposed (and continues to oppose) government efforts to regulate their product, ‘big food’ is behaving in a similar manner (Brownell and Warner 2009).

Ideas matter and ideas in public health are of particular interest and concern as we finally grasp the simple fact it is not health care that has the biggest impact on the health status of the population. Rather, our health status is much more a function of the care we receive as children, the degree of inequality in our society, the nature of our cities and our built environment, and the nature and quality of our jobs, to name but a few determinants of health. The role of ideas in each of these health determining domains will arguably be somewhat different but in all cases public health arguments for policy change will incorporate references to both science and social justice, however elusive these concepts may ultimately prove to be.

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