Commentary

Market failure is bad for your health but social injustice is worse

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Smith and Petticrew succinctly outline the challenges we face in evaluating the impact of public health interventions tackling social determinants: challenges driven by multiple agencies with varying and sometimes conflicting interests, complex causal pathways and outcomes that extend beyond health. Looking ahead they call for a new evaluation approach, one that focuses on the whole before it focuses on any single part: a macro- rather than a micro-approach.

They generously invite comment, which is valuable as their conclusions are important and bear repetition and re-emphasis.

Some readers may take issue with points they make along the way. Does the contemporary agenda on socio-economic factors really represent a move away from infectious disease when prevalence of diseases such as tuberculosis remains one of the most blatant indicators of a breakdown in social and economic structure? Is the interest in social determinants really so recent or have the authors overlooked the efforts of Farr, or Virchow and others who followed who saw poverty and its associated social and political conditions as the root cause of ill health and political reform, economic development and education as legitimate instruments of public health?

Others will not see themselves in the simple portrait painted of the micro-evaluation even when they locate themselves in that camp. The use of mixed methods, while not common, is not the exclusive domain of macro-evaluation. Complex logic models and techniques such as structural equation and multi-level modelling belie the claim that only single cause-effect models are employed. Measurement of non-health outcomes such as community capacity, empowerment, educational achievement and employment features in many evaluations of public health. Perspectives extend way beyond patients and health professionals. Indeed the field of community-based participatory research has developed sophisticated protocols and codes of ethics for involving community partners in research.

We could discuss any of these issues, but I would like to take us back to a point made in the introduction, specifically that public health intervention is best limited to instances of market failure, to challenge and examine the consequences of this framing.

Market failure is the term that economists use to describe situations where one person incurs costs or enjoys the benefits of another’s action. Second hand smoke and the spread of infectious disease from the unvaccinated are prime examples. Government intervention may then be warranted to correct the imbalance. Market failure limits when government can act and what it can do when it does act. For example, the great public health reformer, Edwin Chadwick used market failure to argue for publicly funded improvements in sanitation and to limit any obligation government had to address other social ills such as poverty and homelessness.

But economic considerations such as market failure are just one rationale for government intervention. Social justice is another. Chadwick acted not out of any sense of social justice but in defence of class interest: as evidenced by his administration of England’s poor laws. Concerned that relieving the poor of the health consequences of their unsanitary habits might encourage slovenly behaviour, Chadwick’s
answer was to increase the costs of poverty through the harsh conditions of the workhouse.

The re-emergence of public health’s interest in the social determinants of health is not driven by some muddled notion of ‘population’, as Smith and Petticrew allege, but is a reflection of the re-surfacing of social justice as the motivation for action. It represents outright rejection of the economic/market argument.8

Two consequences follow this analysis. The first is that health will remain a privileged outcome—even in comprehensive evaluations of social interventions—standing above but not disconnected from other outcomes. Why? Because promotion of health and the reduction in health inequalities have more widespread support as objectives of social policy than equivalent outcomes in housing or transportation, and if the health card is to be played to bolster claims on resources for social change we need to make sure the policy has the desired health effect. Thus, there is no paradox in Sir Derek Wanless’s call for more cost-effectiveness evaluations of social policy: such evidence is essential.

Second, we need to scrutinize the rhetoric used to describe the scope of public health practice. Economic arguments are still used today by vested interests in tobacco, alcohol and fast-food to bolster their positions and limit public health action.9 The concept of market failure focuses attention on what is and what is not in the domain of free choice, distracting attention from underlying inequities. It relegates government to providing health education where regulation might be more effective. Public health evaluation in the 21st century is therefore not just about levels, sectors, methods, disciplines and stakeholders. It is also about political values. This behoves the evaluator to interrogate and surface deeply held and often invisible values and the interests they serve.

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References

9 For an example of the arguments used by the tobacco industry to limit government action see Glantz SA, Balbach ED. Tobacco Wars: Inside the California Battles. Berkeley: University of California Press, 2000.