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EDITORIAL

Towards a theoretically grounded, social democratic public health

The Editorial Board recently made revisions to *Critical Public Health's* (CPH) Aims and Scopes. One change was to explicitly invite submissions focusing on the political economy of (public) health and to add political science and policy studies to the (non-exhaustive) indicative list of disciplinary perspectives that shed important light on issues of equity and power in public health.

With those changes in mind, a recent paper by Walby, published in the *European Journal of Social Theory* (Walby, 2021) caught our eye. The paper considers the question of social theory as it relates to public health, specifically in the context of the COVID-19 pandemic. Briefly (the reader is encouraged to read the excellent full paper), Walby draws on Delanty's (2020) review of the response of social theory to the impact of COVID-19, which identified six political philosophical positions on the relationship between the individual and society: utilitarian, Kantian, libertarian, biopolitical securitisation, post-capitalism, and behaviouralism. Walby points out that the concept of 'social democracy' is "curiously absent" amongst these positions. She defines social democracy in relation to public health as "a project, form of governance and societal formation, in which if one is sick, we are all potentially sick". Its omission, Walby argues, is significant because "social democratic visions and practices underpin the theory and practice of 'public health'" (2021, p. 24). In Walby's view, a social democratic public health is one which offers "solidaristic provision of welfare to support [everyone]", thus making it "both efficient and just simultaneously" (2021, p. 38). Here we see a combination of nuanced concerns around the intersection of effective governance and social justice. Critical theory in this journal has been, perhaps, skewed towards Foucauldian perspectives that position public health regimes as biopower, contributing to surveillance. There is a need for public health and other critical theorists to focus on the potential for a more positive, social democratic model of public health.

In this editorial, we seek to address the question of what public health communities might have to do, to ensure that we foreground and prioritise social democratic visions and practices. Walby's analysis raises three crucial issues for public health scholars to consider. Firstly, through the ways in which it mobilises different modes of social theory to characterise the public health response, it provides a modus for thinking about the form and function of social theory in the processes and practices of public health. In turn, this allows us to put into perspective some dominant trends – including blind spots – in critical public health. For example, through mobilizing the biopolitical perspective, Foucault is frequently invoked in critical contexts to analyze 'state-authorized' public health measures to contain communicable disease spread (including but not limited to COVID-19) such as lockdown, distancing, and contact tracing, as unjust forms of authoritarian surveillance and disciplining. Walby's discussion raises issues of how to balance critical approaches to public health which have traditionally focused on its role as part of the apparatus of state control with social democratic approaches which position is a bulwark against neoliberal states.

A question this raises for us is how best to consider the implications of Walby's social democratic theorization of public health state intervention, and how best to develop this as a dominant alternative theorization to neoliberalism in public health. From a cursory review of output from this journal it is apparent that this is a perspective that is largely missing from CPH. It is our view that a social democratic theorization of public health allows for the prioritising of a model of public health that is mobilized in the interest of social justice and democracy. Consider, for example, important research within Latin American social medicine traditions (e.g. Adams et al., 2019).

A second important contribution of Walby's paper is that its focus on social democracy offers a shift from critique to (theoretically robust) construction. The word 'critical' in our title ostensibly is about thoughtful analysis of both problems and opportunities for public health. In reality, however, discussion of problems is overwhelmingly more common in our pages than discussion of opportunities. For example, we note the large amount of attention devoted to criticizing neoliberalism (Bell & Green, 2016).

Indeed, the model of social democratic public health can be regarded as a theoretical socio-political alternative to neoliberal models. This alternative approach, rooted in models of collective solidarity, speaks in direct contrast to libertarian, economistic individualism. In the spirit of the recognition that it is often easier to identify problems than to develop solutions, we take Walby's constructive, critical points to heart. A focus on problems rather than solutions is problematic in that those who propose and implement downstream public health policy focussed on individual lifestyle factors are, through their practice, defining the (narrow) contours of possible solutions. There is a need for critical public health communities to find constructive ways of developing and incorporating social democratic alternatives into public health practice.

Finally, Walby's application of an explicitly social theoretical model of public health as a social democratic intervention by states effectively functions to untether public health from medicine and epidemiology. Both of these disciplines tend to be underpinned by a model of pathology within individual bodies and are typically held by their proponents to comprise apolitical and atheoretical evidence-based science. Bell (2012) offers an apposite critique of evidence-based models, which in turn facilitates problematization of these behavioural turns, where the impact of social inequality is framed as a problem of individual lifestyle factors. There can be no doubt that the relationships between public health and epidemiology and medicine are deeply problematic and demand ongoing critical analysis of the hierarchies and institutions (research, education, and policy/practice) that perpetuate them. There are many excellent examples of such scholarship in this journal. However, it seems that this potential, to build an alternative, social democratic version of public health, grounded in social theory, has not made significant inroads into public health policy and practice.

It is in this regard that we consider one of the most well-known definitions of public health. It is nearly 35 years ago that Acheson (1988) talked about public health as *the art and science of promoting health and preventing illness through organized efforts of society*. While these types of characterisations of public health have long permitted us to move beyond a techno-medical version of public health, this has not happened in any sustained way. McMahon (2022) in this issue describes the multiplicity of understandings of the 'upstream' metaphor across public health practitioners, with few perhaps framing it as broader state efforts. Indeed, critical scholars are sometimes complicit in this problem, by critiquing an amorphous, ill-defined model of 'public health', treating it as a singular, uniform field; or without identifying which explicit elements are the problem. Can critical public health scholars begin to move towards the de-medicalized version of public health; or are we too attached to critiquing it to let it go? There is a need for critical public health scholars to develop their praxis towards de-medicalising, rather than simply critiquing public health.

Walby (2021, p. 36) uses the model of social democratic public health to identify several different possible ways of understanding social responses to crisis (i.e. in the context of the COVID-19 pandemic). These include a temporary aberration followed by a return to normal; a disaster or catastrophe from which recuperation is not possible; and a moment of major change, in which the old is destroyed and new structures and institutions emerge. In terms of this third type, we contend that the COVID-19 pandemic has opened a window for the assertion, or more accurately, re-assertion of social democratic forms of public health. Green et al. (2022), in this issue, argue that this will require a more nuanced incorporation of the 'publics' of public health. In the face of a global pandemic, there was clearly the need for a social democratic response rooted in collective solidarity. We see this imperative evidenced in some interventions, such as mask mandates and income and housing supports (amongst others) but it raises many questions, including for *Critical Public Health* communities. Given the obvious social democratic imperative, how is it that governments managed to mobilize narratives and structures to limit and pre-empt these responses, in favour of a neoliberal/technical version of public health? The mobilization of

a narrative of individual responsibility marks a triumph of arguments about economic wellbeing (and indeed, a particular – neoliberal – version of economic wellbeing) over arguments about population wellbeing. What vested interests, and processes, have obstructed a social democratic vision? How have international responses differed by democratic form – and with what outcomes? How might we reinvigorate and mobilize a social democratic version of public health? What would this mean, if anything, for public health's tethers to medicine and epidemiology and to institutions of research, education, practice, and policy?

We are not alone in raising these issues. Mykhalovskiy et al. (2019), in this journal, eloquently described different types of relationships between critical social science and public health (as an applied field of practice), detailing three types: 1) critical social science *in* public health, 2) critical social science *of* public health, and 3) critical social science *with* public health. While all three types have strengths and challenges, critical social science *with* public health is an aspirational relationship, where critical scholars engage directly with applied public health actors while remaining committed to the specificity of social science theory and methodology. It requires epistemic, disciplinary, and professional collaboration and humility.

A social democratic version of public health, inasmuch as it aspires to something better (usually, arguably, the domain of mainstream public health), while retaining robust theoretical grounding, potentially represents a version of critical social science *with* public health, that brings together the best of mainstream/applied and critical communities, in the spirit of justice and democracy. The question we are left with is how best to constructively develop and sustain opportunities for a social democratic model of public health. We anticipate that this journal presents an ideal context to undertake such activity.

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