The population, its health and social sciences

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Abstract

This commentary provides a glimpse into a conceptual history approach to the topic of public health. I focus primarily on the history of public health during the first half of the 20th century. I will also reflect on its entanglement with the social sciences in later times. The first two sections discuss three core elements of the concept of public health: the "public" or collective that the term refers to, "health", and finally, "public health" as "health of a collective". These elements are historical and political concepts, which means that they do not have a fixed definition, but need to be placed in their historical and political contexts. In the final section, I discuss some connections between social science and public health during the 20th century.

The collective

In the Nordic languages, the concept of public health literally translates to "people's health". While the terms are often used synonymously, their semantic characteristics prompt different associations. The Nordic terms have a connotation with a specific group of individuals, whereas the English "public" is more ambiguous.

Nevertheless, the Nordic as well as the English terms all point to a similar entity: the collective.

The collective has been denoted by different historical, political and medical terms, such as population, people, folk or race. In the era of racial hygiene (or eugenics, as it was called in the Anglo-American world) from the late 19th to the mid-20th century, these concepts were

closely intertwined. Individuals were thought to belong to different races that possessed specific physical, social and moral characteristics. These racial conceptions often coincided with demarcations of the "people", "folk" or "population". Their various uses came to connote who belonged to the collective and who did not.

The definitions were often formulated by social and political elites. Along with the rise of nationalism, the idea of a distinct collective became important for nation-building. "People" and related concepts were thus intertwined with notions of society, the civic community and the nation itself. This is reflected in expressions such as "the British race" when referring to the British nation (Teitelbaum & Winter, 1985, p. 47), or the Finnish term for citizen (*kansalainen*), directly derived from the word meaning "people" (*kansa*) (Harjula, 2015, pp. 18, 48).

While concepts such as "people" might sound inclusive, they were (and are!) complex ideas with various subcategories, and their meaning has also varied according to time, place and actor. "People" could refer to a broad collective that possessed certain characteristics, encompassing different social classes and groups. "People" has also been used to refer to a specific group, a stratum or other smaller entities of people, such as the working class. The term has been used as an empowering concept by left-wing movements, distinguishing the working class from the bourgeoisie and elite. Then again, the middle and upper classes have perceived the "people", understood as the working class and lower classes, as a source of concern: a group that the social or medical elite needed to educate and help and/or control. Top-down approaches could also have marked gendered aspects: "people's education" on hygiene, nourishment and the proper upbringing of children was directed specifically at women, whereas alcohol abuse was framed as a redominately male issue that became a social and public health problem. These gendered demarcations were often coupled with the lower social classes, but they also served as a

framework for controlling and helping problematic individuals within the middle and upper classes.

The notion of "people" (or similar concepts) thus included various inclusive and exclusive criteria. They were associated with specific ideals and norms; deviations from these ideals and norms were perceived as undesired. These conceptions were reflected in expressions such as "good citizen", "asocial individual" or "social problem". The norm was thus constructed by defining both desired and undesired behaviour and characteristics.

Notions of ideal and undesired behaviour for the collective were connected with notions of healthy and normal and, conversely, unhealthy and abnormal. Given that there were several ways of understanding and using collective terms such as "people", the meaning of normative concepts such as "health" and "normal" also varied. (For further discussions on historically and politically flexible concepts such as "health" and "normal", see, e.g., Berg, 2009, pp. 22–34; Hacking, 1990, pp. 160–169; Harjula, 2007; Johannisson, 1991; Qvarsell, 1994; Vallgårda, 2004.)

Many endemic diseases (often labelled "people's disease" in the Nordic languages) and health problems were associated with social class and gender. Some diseases, such as tuberculosis, were seen to be caused, or at least facilitated, by the harsh working and living conditions and the overall poverty that the working class had to endure. This perspective that connected a difficult living environment with health-related hardship reflected ideas of social hygiene. Racial hygienic ideas, on the other hand, emphasised heredity. Heredity was not understood merely in biological-genetic terms, but social and moral characteristics were also believed to be inherited. In the Nordic countries, this idea of heredity was not only linked with racial categories, but also class. In this framework, lower social classes were seen to be more prone by nature to social, moral and physical/biological vices, such as alcohol abuse, mental illnesses (schizophrenia and

feeble-mindedness, in particular) and sexual promiscuity. These "inborn" qualities, for their part, were linked with phenomena labelled as social problems, such as criminality and prostitution.

It should be noted that the distinction made above between social hygiene (also called social medicine) and racial hygiene is purely analytical. In contemporary discussions of the early 20th century, social hygienic, racial hygienic and public health concepts and ideas were closely intertwined.

Whose health?

When analysing public health as a historical and political phenomenon, a central question is to identify whose health is defined and influenced. Public health serves as an apparatus for transforming a group of people or an issue concerning a group of people into an object of knowledge and political action, i.e., into a question to be dealt with by public intervention. This "public health gaze" has been directed at various and overlapping groups and issues over the course of the 20th century. An illuminating demonstration is the aforementioned public health concept of "people's disease" (*folksjukdom*, *kansantauti*; "national disease" in modern-day English), which has been (re)defined differently in different times and countries.

Labelling something as a public health problem thus politicises a health-related issue and the group of people it is seen to affect the most. In other words, they are problematised and therefore given a spot on the public political agenda, whereas other issues and groups are regarded as matters of lesser collective concern and are thereby left off the agenda.

Along these lines, in the early 20th century, Nordic public health measures stemmed from a need to help and control the problem-ridden "people" or "population". These measures took various forms, some of which we would today rather naturally deem to be the responsibility of, for example, social services. Ambulant public

health nurses and midwives provided help and education for poorer families. Rural areas were a particular source of concern: scarce medical care and poor nutrition were linked with high maternal, infant and child mortality and poor health. Mental hygiene and child guidance addressed mental health and behavioural issues of troubled children in order to prevent them from growing up into asocial and criminal adults (Bergenheim, forthcoming; Ludvigsen, 2010; Piuva, 2005). Tuberculosis was addressed through a network of sanatoria, dispensaries and ambulatory care as well as the Calmette vaccination. Venereal dispensaries and sanatoria initially served as a means to control prostitutes. When the harmonised new Nordic marriage laws defined untreated venereal diseases as a marriage impediment, the treatment of venereal diseases officially broke away from the issue of prostitution (although the link continued to exist more indirectly) (Blom, 2006).

Venereal diseases were not the only health-related stipulation for marriage. In the 1920s–1930s, all Nordic countries enacted marriage and sterilisation laws that sought to prevent undesired hereditary qualities (e.g., mental illnesses, deaf-muteness and epilepsy) from being passed on to future generations, thereby weakening the "quality" of the population (Melby, Pylkkänen, Rosenbeck, & Carlsson Wetterberg, 2001, 2006). This was a rather classic form of negative racial hygiene. A textbook example of positive racial hygiene, on the other hand, was the mothers' award distributed by the Public Health Association of Swedish Finland to mothers with several healthy children. To be eligible, both parents had to fulfil specific social, cultural and health-related criteria: they should come from "good", Swedish-speaking families with no history of hereditary diseases, mental illnesses or alcoholism (Bergenheim, 2018; Mattila, 2016).

These examples demonstrate how public health, or "people's health", should be seen in view of its complicated structural origins and, as such, as a concept greater than the sum of its

parts. What could be designated as "public health" at the time was not about just one "people", or one definition of "health". Specific health-related issues were defined as problems as well as being linked with a specific group of people; this turned certain health-related issues, as well as certain groups of people, into social, moral and biological threats to a larger collective. Public health was a holistic framework that crossed boundaries between the social and medical spheres, but drawing rather clear borders around issues and people to be dealt with.

As hinted earlier, public health was also an important part of 19th- and early-20th-century nation-building processes and nationalism. It was intertwined with pronatalist population policy, which linked "population" with "nation". A productive and large enough population was seen as the backbone of a functioning and developing society and a geopolitically strong nation. Productivity was understood not only as economic productivity, but also reproduction – the nation and society needed a large population consisting of socially, mentally and physically healthy individuals who played their part for the common good. Reproduction was not seen as a private matter, but as a civic duty to society and nation. Families (primarily mothers) also carried the prime responsibility for raising new generations of socially and morally healthy citizens. The responsibility of the state was to encourage procreation and support families with children.

Public health, population policy and racial hygiene were hierarchical constructs: the collective prevailed over the individual. It was therefore deemed legitimate to intervene with individuals who deviated from social or medical norms, since they burdened or posed a threat to the collective. Furthermore, it was about controlling the future of the collective and the nation (Bergenheim, Edman, Kananen, & Wessel, 2018). The emphasis on social, moral and biological heredity as well as the strong focus on families and children implied that hope lay with future, better generations.

As of the 1970s, so-called New Public Health, along with large-scale evidence production through epidemiologist methods, advancing statistics and new conceptualisations, began to switch the focus from the collective and future generations to the individual and present generations. Concepts and programmes such as Health for All and "health promotion" emphasise the autonomy, rights and responsibilities of the individual in regard to their own health. In this sense, the tables had turned: public health became all about the health of the individual, and individual rights prevailed over the collective. Epistemically, it has also meant that the concept of the collective came to consist of the sum of individuals to be governed, for example, through evidence-based risk calculations (see Petersen & Lupton, 1996). Risk calculations and other similar tools tend to convey more subtle forms of individualistic and internalised governance, or (self-)governmentality, if you will. They have been criticised for assuming that the rational individual only needs to be presented with an applicable set of facts in order to be able to make sound (medical) decisions. Such mechanisms thereby disregard other important factors and determinants, and externalise responsibility to the individual.

Social sciences and public health

Physicist Thomas Kuhn's seminal work *The Structure of Scientific Revolutions* (1962) ruffled many feathers when it was published. Kuhn viewed scientific progress as being shaped by certain dominant ontologies that steer the ways in which disciplines approach reality as well as their understandings of their own role and mission. This approach challenged a positivist view of science as a linear and accumulative platform of knowledge that is disentangled from subjective belief systems. Furthermore, he claimed that scientific communities undergo paradigm shifts, which throw the community into a state of disarray and chaos until the competing paradigm has established its hegemony. In short, Kuhn represented

scientific progress and knowledge as a socially and historically contingent and constructed phenomenon. In the late 1960s, the discussion stirred by Kuhn's contribution was complemented by another formative topic: the linguistic turn. It emphasised the role of signification and language in how humans perceive and attribute meanings to the surrounding reality. In other words, the core claim was that the language used for describing and dealing with reality shapes the way we see the world and that there exists no truly objective social reality.

During the period primarily discussed in this text (1900s–1950s), scientific knowledge was in general viewed through positivist lenses also in the social sciences. There was a firm belief that objective, rational facts about the human being and its behaviour could be achieved through extensive and systematic empirical data. Empirical social sciences were paralleled with the natural sciences.

As has been established above, public health and population policy framed the health and productivity of the population as a national and collective interest. This created a demand for research, data and statistics in order to optimise productivity and identify and address problems. These aspirations were closely linked with social engineering and social planning, even though the Nordic countries differed in how and when these discussions took place. In Sweden, Gunnar Myrdal had a vision of social engineering and policy-orientated social science as early as the 1930s (Jackson, 1990, pp. 104–106). In Finland, on the other hand, the social planning discourse was a rather short-lived latecomer. It emerged in the 1950s primarily as a means of bridling reckless and expensive social policy. In the early 1960s, it tipped over to "planning optimism" (Saloniemi, 1996). Social scientist Pekka Kuusi's book _60-luvun sosiaalipolitiikka_ (1961) (in English: _Social policy for the sixties: A plan for Finland_) is seen as a classic in this respect. It optimistically hailed a carefully planned, science-based social and health policy programme as a means of ending poverty once and for all. By the 1970s, the Myrdalian/

Keynesian ideas that Kuusi's book was based on were yet again challenged (and defeated) by neoclassical economic ideas.

Not everything has changed, however. To this day, public health deals with complex wholes that are inherently difficult to govern: human beings and communities of human beings. In order to identify problems, define goals and implement a holistic approach to public health, the objects of knowledge and action have to be approached from several angles. On policy level, this is reflected in the way public health crosses and blurs the boundary between social and medical perspectives. It is also reflected in how public health has overlapped with numerous other policy strands, such as social policy, population policy, housing policy and family policy.

This holds true for public health as an academic discipline as well. By definition, it studies health-related phenomena in a broad social context. It thereby shares kinship with the academic disciplines that deal with the same themes as the above-mentioned policy strands. Sociology, social policy, demography, architecture and urban studies, social psychology, social medicine, etc. are all specialised in identifying and analysing social phenomena that have an impact on an individual level as well as a collective level.

However, this is somewhat overshadowed by a positivist tendency (paradigm, even) of public health. Populations are perceived as large-scale samples for accumulating large-scale data (biobanks are the latest trend in this development). This "public health gaze" is mainly focused on two levels: molecular and medical (big) data, and the generalised or isomorphic facts extrapolated from the data (e.g., statistics, evidence-based risk calculations). This approach upholds the strong link between public health and medicine. Furthermore, it risks forgetting what lies between the two levels: first, the individual (which is rather ironic, given the present era of individualism); second, the social dimension, including social structures.

For public health is not medicine – it is a melting pot of social and medical sciences. It needs and complements both, but can replace neither.

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