Wellbeing Budgeting: A Critical Public Health Perspective

Invited Commentary

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In New Zealand, Wales, Scotland, and Finland, among other countries, wellbeing approaches to policy have become a growing trend over the past decade. Attention to the wellbeing and quality of life of the population has the potential to act on upstream determinants of health and, thus, to be a significant boon for healthy public policy. The National Collaborating Centre for Healthy Public Policy (NCCHPP) seeks to explore the significance of this policy turn. In this briefing note, we invite noted public health scholar, Lindsay McLaren, to assess how wellbeing approaches to policy align with public health scholarship and practice and whether there is a role for public health in this work. Dr. McLaren offers a critical perspective on the state of public health and on the opportunities and risks of embracing wellbeing budgeting as a 'potentially radical approach to realizing some of the core values and goals' of public health. We invite you to read her contribution below.

Briefing Note

For up-to-date knowledge relating to healthy public policy

Introduction and Overview

Wellbeing budgeting (briefly, a framework for government decision-making that is guided by the wellbeing of people and the planet; see more below) is potentially a radical approach to realizing some of the core values and goals expressed in public health research, practice, and policy. That is, it potentially offers a way to address root causes of poor health and health inequities (i.e., unfair, and avoidable, differences in health between social groups; National Collaborating Centre for Determinants of Health [NCCDH], 2013). Alternatively, it could represent a set of activities that are downstream and ineffective when it comes to those goals.

Because of the relatively new and evolving nature of wellbeing budgeting, there is an important opportunity to work towards advancing the former, more radical version. The starting point for this briefing note is that public health communities should be involved, in some way, in wellbeing budgeting discussions, but that a critical perspective is required. Public health communities include decision makers, practitioners, scholars, and activists. It recognizes, of course, the many individuals and groups whose work is highly pertinent to public health and wellbeing yet who may not identify as being part of public health. Notwithstanding the persistent challenges presented by these boundary issues (which are related to the identity crisis noted below), my use of the phrase "public health communities"—in which I include myself—is deliberate and intended to convey the value of working towards a collective with unity of purpose. The purpose of this briefing note is thus to consider wellbeing budgeting from a critical public health perspective, concisely described by Schrecker (2021) as a perspective that speaks truth about power, through: a normative commitment to health equity; recognition that inequities are constructed and maintained through social, political, and historical forces; and acknowledgement of the insidious impacts of medicalization which obscure macro-scale determinants of wellbeing and health equity.

To set the stage for engagement by members of public health communities in wellbeing budgeting conversations, this briefing note has two main sections. The first defines and unpacks wellbeing budgeting and public health, identifying potential points of alignment. Public health is defined in a way that embraces applied practice, activism, and scholarly inquiry aimed at understanding and improving wellbeing and health equity in populations. The second, lengthier, section identifies challenges and opportunities for public health communities when engaging in wellbeing budgeting conversations. Briefly, participating in these conversations provides an opportunity for public health communities to "walk the talk" of the social determinants of health, by keeping our gaze focused on upstream factors shaping wellbeing and health equity. To be effective,

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however, in pushing back against neoliberal[1] objectives that are contrary to our stated values and goals, public health communities must find ways to engage with power and politics. Finally, wellbeing budgeting provides an opportunity for critical thinking around the concept of wellbeing itself, including its definition(s), connotations, and relation to health (itself a contested concept).

The timing of this conversation is significant, for at least three reasons. First, the abundantly unfair distribution of risk and impact from the COVID-19 pandemic (Public Health Agency of Canada [PHAC], 2020), coupled with extreme ecosystem risks presented by our unsustainable demands on the natural world (Canadian Public Health Association [CPHA], 2015; Dasgupta, 2021) reflect institutional failure on a grand scale, and provide an opening for big ideas (see United Nations, 2020). Second, there are some indications that the stage is being set for wellbeing governance in Canada; these include the federal government's Quality of Life framework, released by the Department of Finance as part of the 2021 federal budget (Department of Finance Canada, 2021; Morrison & Lucyk, 2021). Third, the field of public health is experiencing a prolonged identity crisis. Public health is widely misunderstood by those outside of the field, and there are tensions within, including between scholarly and applied communities (Castrucci et al., 2020; Lucyk & McLaren, 2017; McLaren & Hennessy, 2020). Its capacity and impact have—perhaps accordingly—been described as weakening across Canada (Guyon et al., 2017; Potvin, 2014). Wellbeing budgeting potentially offers a focus around which public health communities could mobilize (and thus begin to address our identity crisis), if we can agree that 1) the goal is stronger conditions for health and wellbeing for all, including for future generations, and 2) we must be collaborative and humble in working towards that goal.

In line with the explicit audience of the NCCHPP, the intended audience for this briefing note is public health communities, broadly defined.

What is Public Health, and How might it Align with Wellbeing Budgeting?

Public health: Organized effort of society to keep people healthy and prevent injury, illness, and premature death (CPHA, n.d.).

Public health is conceptualized here as a field of applied practice and scholarly inquiry that—at least ostensibly—brings unique elements to understanding and improving health and wellbeing. Distinct from biomedicine and other aspects of health care, public health is characterized by a focus on populations and an emphasis on primary prevention,[2] nested in upstream thinking about root causes of poor health and health inequity (CPHA, 2017; McLaren & Hancock, 2019). Moreover, in line with its intersections with social sciences (Baugh-Littlejohns et al., 2019; McLaren, 2019), public health activities are—again, ostensibly—conceptually anchored in critical perspectives (e.g., political economy of health) that are concerned with collective and structural processes that shape wellbeing and health equity (Harvey, 2021; Raphael et al., 2020). In theory at least, public health endorses a version of health that is positive (i.e., not just about disease or its absence), dynamic, and multidimensional, and thus includes wellbeing (Potvin & Jones, 2011; World Health Organization [WHO], 1946; WHO, 1986).

Embedded in these attributes, and as recognized by the CPHA definition provided above, is recognition that efforts to improve health, wellbeing, and health equity must go beyond the health sector (i.e., beyond the health care system or the ministry of health) (Commission on Social Determinants of Health [CSDH], 2008; Raphael et al., 2020) to keep people healthy in the first place, which requires attention to the social determinants of health. The social determinants of health—such as how income and wealth are distributed, employment status and quality of working conditions, availability and accessibility of health and social services, and one's ability to obtain high quality education, food, and

[1] Neoliberalism is the current version of capitalism, which began to gain global dominance in the late 1970s / early 1980s and is characterized by a hegemonic emphasis by governments on protecting private wealth and restoring the economic and social dominance of private business. Public policy under neoliberalism focuses on (among other things) privatizing and deregulating industry (including weakening labour standards); using free-trade agreements to expand markets and constrain government interference; and reducing or undermining social policies, thus disinvesting in the broader public good (Stanford, 2008).

[2] Primary prevention refers to actions to prevent the occurrence of disease or injury in the first place by reducing or eliminating exposure to hazards or risks, including by tackling directly the environmental, economic, and social conditions that create hazards or risks. The term thus includes what some describe as 'primordial prevention'.

housing—reflect policy decisions across governments, including their ideological underpinnings (CSDH, 2008; Raphael et al., 2020).

This fundamental understanding underpins the notion of healthy public policy (Hancock, 1985), which aims to put health on the agenda of policy makers in non-health sectors (WHO, 1986). It also underpins the substantively similar but more recent emergence of Health in All Policies, which aims to systematically consider the implications of decisions across public policy sectors for population health and health equity (Kershaw, 2018; NCCHPP, n.d.-a; Shankardass et al., 2012; World Health Organisation & Finland Ministry of Social Affairs and Health Finland, 2014). To the extent that both concepts incorporate a broad definition of health that includes wellbeing, they are potentially consistent with a wellbeing budgeting approach.

While the COVID-19 pandemic has pushed public health into the spotlight, it has reinforced a narrow version focused on communicable disease control led by the health care system. Although attention has been drawn to health inequities (e.g., racialized disparities in COVID-19 risk and impact) and to mental health consequences of the pandemic, it is not at all clear that those outside of the field draw a connection between these issues and public health (versus the broader health care system). This pervasive failure to make a connection between health and the broader socio-economic environment (Manuel, 2008; Snyder et al., 2016), including by some members of public health communities, undermines a Health in All Policies approach, or indeed any coherent vision that embraces what is known about the primary determinants of health, wellbeing, and health equity (Hancock et al., 2020; McLaren & Hennessy, 2020).

Wellbeing Budgeting and Public Health

As a general concept (e.g., Moss, 2020), wellbeing budgeting embodies a felt need to redefine how societal success is conceptualized and measured, and it offers an alternative frame for doing so. Its point of departure is the problems associated with the current decision-making framework in governments (i.e., the framework for budgeting and planning), which, in the context of neoliberal capitalism, gives primacy to market-oriented objectives and the enhancement and protection of private wealth. While such a framework is effective for generating narrowly conceptualized visions of wealth (e.g., economic growth), it also tends to distribute harms and benefits unevenly, which perpetuates social inequities and ecological challenges that reduce wellbeing and quality of life for present and future generations (Dasgupta, 2021; Durand & Exton, 2019). Social inequities in health, and ecological determinants of health, are concerns that public health communities care deeply about (CPHA, 2015; Lancet Countdown, n.d.); or at least claim to.

Wellbeing budgeting recognizes that wellbeing-related outcomes transcend jurisdictional levels and traditional policy domains (Global Happiness Council [GHC], 2019; Barrington-Leigh, 2020). In other words, it recognizes that wellbeing outcomes cannot be achieved through the activities of a single department or ministry. Wellbeing budgeting could therefore represent a way to advance the cross-sectoral intentions of a Health in All Policies approach, towards creating the economic and social foundations to support wellbeing for all.

By recognizing and aiming to redress the considerable drawbacks associated with our current market-oriented economy, a wellbeing budgeting approach aligns closely with social determinants of health scholarship (CSDH, 2008; Raphael et al., 2020; Ruckert & Labonté, 2017). The drawbacks are well documented and easily illustrated. Canadian and international data consistently show that economic growth (e.g., rising gross domestic product [GDP]) does not 'trickle down'; rather, the benefits of growth have accrued mostly to those who already have high levels of income and wealth, while incomes at the bottom have stagnated, leading to widening income inequality (Lawrence, 2001; Macdonald, 2021; Organisation for Economic Co-Operation and Development [OECD], n.d.). Likewise, our current economic system has permitted massive deterioration of biodiversity (Lancet Countdown, n.d.). This is because it has not incorporated consideration of the benefits of nature to society, and thus (perversely) permits and in fact encourages activities that destroy nature: "Governments almost everywhere exacerbate the problem by paying people more to exploit Nature than to protect it, and to prioritise unsustainable economic activities" (Dasgupta, 2021, p. 2).

As long acknowledged by scholars anchored in traditions of critical public health, health promotion, and political economy of health (e.g., Bump et al., 2021; Potvin & Masuda, 2020), these elements of neoliberal capitalism have significant negative consequences for health, wellbeing, and heath equity (CPHA, 2015; CSDH, 2008; The Lancet, 2019; Wilkinson & Pickett, 2009). Wellbeing budgeting—at least theoretically—offers an alternative framework for government decision-making that favours the ideological commitments of public health and allows for an approach that prioritizes the health and sustainability of the planet and the quality of peoples' lives (CPHA, 2015; WHO, 1986).

Challenges and Opportunities for Public Health Communities: A Critical Thinking Imperative

Considering the points of alignment summarized above, wellbeing budgeting may represent an important opportunity for members of public health communities to work collaboratively and humbly towards advancing our stated values and goals. Possible roles for public health actors include articulating the rationale to different audiences, helping to advance the agenda within governments, and providing expertise around defining a framework, indicators, goals, and evaluation.

Wellbeing budgeting could, however, turn out to be simply a repackaging of existing ideas in public health (i.e., healthy public policy; Health in All Policies) which remain substantively unrealized. Towards substantive realization, the sections that follow articulate some opportunities and challenges for public health communities, all of which are grounded in the need for a critical perspective. The first section identifies that wellbeing budgeting offers an opportunity for public health communities to "walk the talk" of the social determinants of health, by keeping our gaze focused on upstream determinants of poor health and health inequity. The next section goes on to emphasize that improvements to the social determinants of health will not occur if key problems of power and politics are left untouched. If the goal is creating conditions for population wellbeing and health equity, public health actors must find ways to engage with power and politics, both within and outside of our field. The final section articulates challenges—and opportunities—concerning the concept of wellbeing itself, including definitions, political connotations, and its relation to health.

"Walk the Talk"

Public health is concerned with social, economic, ecological, and colonial determinants of health and wellbeing. Yet, deep engagement by public health communities with the upstream, public policy antecedents of those determinants is—on the whole—limited. This reflects several factors, including the persistent problem of lifestyle drift where—due to a constellation of historical (i.e., dominance of medicine), ideological (i.e. neoliberal individualism; institutionalized entrenchment of power), legislative (i.e., presence or absence of mandate and supportive legislation), and practical (i.e., apparent simplicity and intuitive appeal) factors—prevention policy focuses narrowly on health behaviours while failing to incorporate a deep understanding of the social determinants of health (Baum & Fisher, 2014; Cairney & St Denny, 2020).

A focus on wellbeing budgeting could potentially help public health actors to "walk the talk" of the social determinants of health, by keeping our attention (and that of other key actors) focused on the policies and policymaking processes, rather than on their downstream consequences. For example, faced with evidence of health inequities, wellbeing budgeting could provide a way to mobilize upstream public sector solutions in domains such as tax policy, public spending, and subsidies to industry (Hancock, 2020; Pickett & Wilkinson, 2018; Smylie, 2015; Stuckler & Basu, 2013).

The COVID-19 pandemic has opened a window to "walk the talk", by prompting broader public discourse around economic policy and dominant narratives. In the face of widespread threats to peoples' livelihoods, the Canadian federal government's pandemic response (e.g., the Canada Emergency Response Benefit [CERB], Government of Canada, n.d., and subsequent versions) was immediate and substantial, and it demonstrated the feasibility (and, indeed, the imperative) of high levels of government spending and debt when necessary (Macdonald, 2020). There is a key opportunity to push back against dominant economic narratives that have otherwise prevented such substantial investments; they have done so by characterizing high levels of government spending and taxation as

harmful (Himelfarb, 2020; Rozworski, 2020; Stanford, 2008):

> *Two decades of tax cuts and fiscal restraint narrowed our sense of what's possible […] But [during the pandemic] we've seen that big things are possible and active government can be a force for good. At this critical moment we cannot allow our decisions about what comes next to founder on misplaced fears about public spending and debt (Himelfarb, 2020).*

As part of "walking the talk" of the social determinants of health, members of public health communities could help to mobilize wellbeing and health equity as additional reasons to advance these counter-narratives.

In these ways, wellbeing budgeting provides a focus for public health advocacy, which is a core competency for public health practitioners (PHAC, 2008). Public health advocacy is sometimes limited or constrained by various factors including employment parameters (e.g., members of the public health workforce in government organizations who are not permitted to speak out) and/or political decisions (e.g., Power et al., 2019). Importantly, however, avenues for collective mobilization exist, such as the provincial/territorial and national public health associations. While some of these associations are active, visible, and impactful; others are sadly under-used despite presenting a strong opportunity for collective advocacy (Canadian Network of Public Health Associations [CNPHA], 2019).

POWER AND POLITICS

While paying attention to public policy is important and necessary, it is insufficient. To "walk the talk" of the social determinants of health requires engagement with power and politics. The paragraphs below serve to, firstly, illustrate that engagement in power and politics is an area for improvement for public health communities; and secondly, offer examples and perspectives that may help us to engage more deeply.

Public Health, Power and Politics: A Significant Disconnect

As critical public health scholars have long recognized, the institutionalized nature of public health itself (i.e., formal or standardized elements of education and practice) is one key barrier to radical action (Bell & Green, 2014). When important concepts (e.g., equity) and ideals (e.g., calls for action on the social determinants of health) are embraced in the mainstream, they tend to be diluted or to "lose their critical edge and radicality" (Skinner, 2018, p. 1).

Two recent examples illustrate this dilution. First, Plamondon et al. (2020) critically analyzed scholarly publications that cited the influential 2008 World Health Organization Commission on Social Determinants of Health final report (CSDH, 2008) in the eight years following its release. That report was unambiguous in its conclusion—based on synthesis of a very large amount of research—that health inequities reflect an unfair distribution of power, money, and resources. Yet, among authors who cited the report, fewer than half acknowledged this key insight and its political implications, and instead mobilized what Plamondon et al. (2020) called "less productive orientations", meaning that they (for example) presented health inequities as natural (and therefore not a viable focus of intervention), or they placed the site for intervention at the individual level through behavioural, biomedical, or neoliberal approaches.

Second, based on growing attention to "vulnerability" in public health research and practice, Katz et al. (2020) explored the use of that term in papers published in mainstream public health journals (see also McLaren et al., 2020). A key finding was that terms such as "vulnerable groups" were often vaguely defined or undefined, which—the authors argued—requires the reader to "fill in the blanks" in terms of who is vulnerable, why they are vulnerable, and what they are vulnerable to. Importantly, that vagueness tends to conceal the structural, intersectional, and cumulative causes of public health problems. Moreover, these authors identified that those in power (i.e., those who are not vulnerable) were rarely studied; in other words, public health research on vulnerability largely omits those who play a role in generating vulnerability by, for example, supporting tax benefits to wealthy

individuals that are financed by reductions to public spending (see also Nixon, 2019).[3]

Thus, while public health communities (including researchers and practitioners) assert concern with the social determinants of health, there are limits to our collective level of engagement with their most difficult elements: those of power, privilege, and politics that create and perpetuate inequalities.

Power and Politics: Opportunities for Deeper Engagement

Finding ways for public health communities, broadly understood, to engage more deeply with power and politics is a difficult task indeed. However, there are opportunities to do better. With reference to wellbeing budgeting, a couple of ideas come to mind.

One concerns participatory democracy, towards public (health) policies that reflect and respect 'the public'. In Canada, there is an important tradition of alternative budgeting (Canadian Centre for Policy Alternatives [CCPA], n.d.; CCPA, 2020). Originating in the work of social activists and progressive organizations in the early 1990s, alternative budgeting (which can be done at any level of government) aimed to demonstrate that there was indeed an alternative to aggressive spending cuts underpinned by a narrative (still dominant today) that such cuts are essential to avoid bankruptcy (Himelfarb et al., 2020; Loxley, 2003; Stanford, 2008). Alternative budgets are developed openly and through consultations, so that those affected by budget decisions can influence the process. Moreover, rather than simply criticize policy decisions (which is not overly difficult), alternative budgeting includes the identification of alternatives within clear fiscal parameters. The relevance of this work to contemporary conversations about wellbeing budgeting is clear from the subtitle of economist John Loxley's book on the subject: "Budgeting as if people mattered" (Loxley, 2003).[4] Connections between public health and alternative budgeting are, to date, regrettably weak.

A second point concerns interdisciplinarity. Because of the perpetual dominance in public health of medicine and biomedical thinking, interdisciplinarity is key to thinking about (and redressing) issues of power. Wellbeing budgeting prompts members of public health communities to learn more about, and to engage more deeply with, disciplines such as economics and political science (e.g., De Leeuw et al., 2014; Dutton et al., 2018; Kershaw, 2020). With respect to economics, although there is important public health research on, for example, the proportion of health care spending devoted to public health activities (Fiset-Laniel et al., 2020; see also McLaren & Dutton, 2020) and return on investment of public health interventions (e.g., Masters et al., 2017), there is relatively less engagement between public health and other aspects of economic policy, such as critiques of the hegemonic elements of neoclassical economics which exert enormous impact on our society and wellbeing (Stanford, 2008). Political science scholars have shed crucial light on the challenges of advancing preventive policy within governments (Cairney & St Denny, 2020). One example is the strong likelihood that an ambitious agenda such as wellbeing budgeting, because of its breadth, could be used to support the status quo. For public health communities to engage in wellbeing discussions without genuine engagement with these interdisciplinary allies would be to fall short.

Further with respect to interdisciplinarity, another challenge (and opportunity) for public health is to find ways to bridge tensions between applied and scholarly domains within the field, which are significant and impede our ability to mobilize as a collective (Lucyk & McLaren, 2017; McLaren & Hancock, 2019). Some guidance in this regard comes from a paper by Mykhalovskiy et al. (2019), which usefully distinguishes between critical social science *in* public health, critical social science *of* public health, and critical social science *with* public health (see Table 1), where public health refers to the institutionalized practice.

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[3] These observations have important implications for research funders and review panels, where unconscious bias may influence what questions are asked, as well as whether, how, and by whom they are answered.

[4] There are parallels, and thus potential points of alignment, between alternative budgeting and concepts that may be more familiar to public health actors including health impact assessment and environmental impact assessment (NCCHPP, n.d.-b).

Table 1 Critical Social Science *in, of,* and *with* Public Health (adapted from Mykhalovskiy et al., 2019)

Type of relationship	Description	Opportunities	Drawbacks
Critical social science *in* public health	Social scientists work within the institutional and discursive spaces of public health (e.g., within a university School of Public Health or a public health department in the health care system).	Can provide a way for social scientists to contribute to applied concerns in public health.	Can erode the unique analytic contributions and scholarly autonomy of social science, because social science theories, concepts, and methods are used in service of public health aims.
Critical social science *of* public health	Social scientists are situated outside of public health, which becomes an object of critical inquiry (e.g., illuminating a tendency to overlook fundamental causes of poor health).	Can identify and yield significant insights into built-in and implicit flaws of public health practices, forms of reasoning, politics, concerns, modes of organization, etc.	Can turn into an entirely negative critique, which points out the failings of public health but does not pursue constructive alternatives.
Critical social science *with* public health	A relationship between social science and public health that recognizes sources of difference and tension and works productively with those differences and tensions.	Begins to address inadequacies of *in* and *of* orientations; may permit productive channelling of conflict towards tackling key problems such as politics of austerity.	Risk of devolving into a superficial and uncomplicated space of shared interests. Requires commitment to reflexivity on both sides (rare), and ongoing engagement.

For critical social science *with* public health, the power and epistemological tensions between scholarship and practice are not ignored or avoided but rather become a site of productive inquiry. To the extent that wellbeing budgeting in its radical sense (i.e., a coherent vision for addressing root causes of poor health and health inequities) requires both critical and applied practice, social science *with* public health will be a necessary foundation.

Conceptual and Operational Clarity around Wellbeing

A final crux concerns the concept of wellbeing itself, including (1) what it is, including how to measure it; (2) how it relates to health (itself a contested concept); and (3) who is, or should be, responsible for leadership of policy activities underpinned by a wellbeing agenda. Embedded in this latter question is the role(s) and implications for the public health sector. The following sections consider these three questions.

The Contested Nature of Wellbeing and its Measurement

There is a considerable amount of scholarship devoted to conceptualizing and measuring wellbeing and related concepts (e.g., happiness, life satisfaction, quality of life). This includes work by the Global Happiness Council (GHC), which has long argued for happiness—grounded in measures of emotional wellbeing, life satisfaction, meaning and purpose, and healthy relationships—as an overarching policy objective (GHC, 2019; see also Barrington-Leigh, 2020). From the point of view of wellbeing budgeting, the idea is that government decisions including allocation of public monies would be guided by whether or the extent to which they contribute to improvements in those measures. In support of such an approach, this scholarship has identified, for example, that countries with the highest levels of happiness, defined using the measures above, are also those making advances towards important objectives such as inclusive and equitable economies and protection of the natural environment (GHC, 2019).

While an overarching focus on happiness or wellbeing may be appealing in its apparent simplicity, it has potential drawbacks. These broad concepts can be defined and understood in many ways, and depending on context they can acquire individualistic and even commercial connotations. In a neoliberal context, characterized by competition, individualism, and consumerism, activities to promote happiness or wellbeing could take the form of placing the onus on individuals to pursue happiness (e.g., through positive thinking or mindfulness) or to privately purchase it (e.g., the "wellness" industry). Such activities distract from addressing enduring structural inequities (Carlisle & Hanlon, 2008).

Indeed, a focus on wellbeing or happiness can underpin intervention approaches that are downstream in orientation. To illustrate, in their discussion of policies to improve wellbeing, the Global Happiness Council identifies "proven school curricula to foster healthy well-being skills and virtues" among children (GHC, 2019, p. 5). In their review of psychological wellbeing and its implications for public health, Trudel-Fitzgerald et al. (2019) identify and recommend several "individual-level positive psychology interventions" (e.g., individual-level activities to increase positive emotional experiences such as optimism and gratitude) on the basis that they are easy to implement and could potentially be scaled up to improve population wellbeing.

While these reports (GHC, 2019; Trudel-Fitzgerald et al., 2019) also acknowledge the need for attention to broader socio-structural factors, they raise concerns—as predicted by the notion of lifestyle drift—that substantive efforts to address inequities of money and power (i.e., root causes of wellbeing) may be crowded out by simpler, downstream approaches:

> *Well-being […] has considerable political appeal. […] Policies to promote well-being across the population may possess greater popular acceptability and vote-worthiness than policies designed around progressive taxation and a fairer redistribution of wealth across society. […] Because the concept has potential to divert policy away from tackling health inequalities, a focus on emotional well-being could be a lightweight distraction or even a serious threat to efforts to achieve greater health equity and social justice (Carlisle & Hanlon, 2008, p. 266; see also Grimes, 2019).*

A critical perspective, by members of public health communities, is required to spot circumstances where downstream interventions are presented as substantive or viable approaches to improve wellbeing, when harmful practices—such as austerity budgets—are going on in the background.

In an attempt to avoid some of these drawbacks, others espouse a multidimensional approach to the conceptualization and measurement of wellbeing. For example, to guide their wellbeing budget, the New Zealand Treasury outlines a Living Standards Framework Dashboard, which includes four forms of capital (natural, human, social, and financial/physical) and 12 domains of current wellbeing (e.g., civic engagement & governance; cultural identity; environment; health; housing) (Government of New Zealand, 2019). In the Canadian context, there is the Canadian Index of Wellbeing which, prompted by the negative impact of the 2008 economic recession on wellbeing and equality, aims to better capture overall quality of life by treating beneficial activities and outputs (e.g., clean air, health) as assets and harmful ones (e.g., pollution, overwork) as deficits (Canadian Index of Wellbeing, n.d.).

These latter approaches may help to address some criticism of singular measures (e.g., happiness), such as their individualistic connotations as noted above. Potential drawbacks of broad, multidimensional approaches include lacking the precision or coherence necessary to provide a clear guide for policy (Cairney & St Denny, 2020; see also Cameron et al., 2006).

Although it is important to think carefully about how to conceptualize and measure wellbeing, there is a risk of fixating on indicators to such an extent that time and effort are disproportionately devoted to describing and measuring, rather than addressing, the problem (Bambra et al., 2010). Moreover, measurement, metrics, and indeed the use of data are also shaped by power, politics and privilege, and a critical perspective is essential for unpacking the political and historical forces shaping data and its use.

With respect to measurement, one could argue that an equally important focus and leadership opportunity is to advance the routine availability of disaggregated data to assess issues of equity. This would include, for example, ensuring that existing data in health (e.g., COVID-19 cases) and economic (e.g., job loss due to pandemic restrictions) domains can be disaggregated along important axes such as race/ethnicity, gender, and ability (e.g., Block, 2021; Scott, 2021) in a timely manner.

How are Health and Wellbeing Related?

Beyond resisting a fixation on indicators, there is the question of how wellbeing and health (itself a contested concept) are related. In theory, health and wellbeing go together under a broad version of health such as that espoused by the World Health Organization over 70 years ago, and subsequently in the Ottawa Charter for Health Promotion (WHO, 1946; WHO, 1986). Importantly, such a version embraces upstream thinking, in contrast to a narrow biomedical version which foregrounds pathophysiological factors and often omits social processes.

Because of this broad version of health, some members of public health communities may feel that we "own" wellbeing; that it falls into our purview as health experts. In practice, however, this relationship is fraught. Health as a domain of public policy (e.g., the term "health policy") usually does not refer to a broad version of health as described above; rather, it refers to a version that focuses overwhelmingly on medical care and hospitals. This reflects, and perpetuates, a very strong tendency by members of the public, politicians, and mainstream media to conflate health and health care, which is a fundamental challenge to a version of public health that embraces social determinants of health (Hayes et al., 2007; Kottke et al., 2016; McLaren & Hennessy, 2020) and that would align with wellbeing budgeting.

The conflation of health and health care (and thus a version of "health" that is distinct from wellbeing) is evident in some wellbeing scholarship. For example, the Global Happiness and Wellbeing Policy Report (GHC, 2019) discusses health care as one of several policy domains that could be guided by a wellbeing lens.

Overall, while some members of public health communities see health and wellbeing as closely related, that viewpoint is not widely shared. This underscores the need for members of public health communities to exercise humility and avoid "health imperialism", i.e., a tendency in the health sector to dominate or to assume shared viewpoints about what "health" is and who is responsible for it (Harris et al., 2012; Oneka et al., 2017).

Who Is (or Could Be) Responsible for Implementing a Wellbeing Agenda?

Some research has shown that intersectoral efforts (of which wellbeing budgeting could be one example) can be compromised under public health leadership, if the public health sector in the setting in question is downstream in its orientation, conceptualizes a biomedical version of health that does not easily include wellbeing, and does not recognize the importance of the social determinants of health (Guglielmin et al., 2018).

Such understanding lends support to wellbeing as an independent layer of decision-making (i.e., not led by the public health sector). An example comes from Wales, where leadership for its wellbeing legislation (Well-being of Future Generations Act) comes from two key positions that transcend existing policy domains: a Future Generations Commissioner (a new position), and the Auditor-General (Future Generations Commissioner for Wales, n.d.). This model is also consistent with ongoing activities in Canada, where—based on 2019 federal ministry mandate letters—it is non-health ministries (e.g., Middle-Class Prosperity; Finance) that are tasked with investigating wellbeing budgeting (Lucyk, 2020).

Conclusion

This briefing note considered wellbeing budgeting from a critical public health perspective. This included defining and unpacking both wellbeing budgeting and public health to identify points of alignment, and then identifying some opportunities and challenges for public health communities; defined broadly to include scholars, front line practitioners, and activists.

There are important points of alignment between the values and goals of public health—as a field of applied practice and scholarly inquiry—on the one hand, and a wellbeing budgeting approach on the other. Namely, because of its cross-government focus, and its concern with inequality and ecological degradation stemming from narrow conceptions of wealth and growth, wellbeing budgeting potentially provides an important opportunity to advance the intentions of a Health in All Policies approach; namely, a cross-sectoral orientation anchored in wellbeing and health equity. The opportunity is not just abstract; it is being actively discussed in Canada (Lucyk, 2020; McLaren, 2020; Department of Finance Canada, 2021; Morrison & Lucyk, 2021).

To realize the radical potential of wellbeing budgeting—meaning its potential to address root causes of wellbeing and health equity for current and future generations—demands a critical public health perspective, where all members of public health communities feel equipped to engage deeply in upstream determinants of health and their underlying dimensions of power and politics. It also raises challenging, but potentially liberating, questions about how we might define a coherent vision for the future of public health.

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Wellbeing Budgeting: A Critical Public Health Perspective

Invited Commentary

2022

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