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La santé, le « wellness » et le bien-être

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1. Introduction

- 1 For responsible Public Policy to effectively enhance overall wellbeing and promote universal happiness, it must be evidence-based, rather than politically or commercially motivated. And in order to prove its validity, policy makers must first fully understand and share information about the problems that hinder improvements. A crucial part of understanding and sharing information is to utilize standard definitions. Confusion arises when different areas of public policy utilize similar words without necessarily agreeing on their exact definitions. Moreover, within broad policy topics there exist specialized areas of study that also use particular definitions whose meanings are not always uniform.
- 2 Public Health, for example, is a broad policy topic with specialized areas. Some health-related terms seem to be similar, but without objective definitions their subjective interpretations can lead to misinterpretation. Two similar concepts within health that are often used loosely and interchangeably are *wellness* and *wellbeing*. Although the two terms are neither officially nor colloquially differentiated, I shall take my first part to explain their divide and the definitions I used to make my assumptions.
- 3 I will then attempt to show current trends in the United States towards health, wellness and wellbeing using health care promotion campaigns and policies. These entities reveal some of the changing concepts of health and how it has become more diverse in the US. In particular, I look at the health promotion campaign *Healthy People* and the *Patient Protection and Affordable Care Act* (ACA), which, although they emerge at the federal level, arrive to more local levels through monitoring, grants and regulations.
- 4 The happy state of wellbeing is important to one's health and longevity, as Diener and Chan (2011) and Diener *et al.* (2017) find. Yet, wellbeing is not fundamental to traditional health and wellness. In the United States health system, the foundation of

basic care necessitates more immediate attention. In 2016, more than 28 million people in the United States, or 9 percent of the country, went without any health insurance (Kaiser, 2018). With so many people uninsured there is still a large gap in the US's health care system. A policy priority that cannot be ignored, therefore, is to get people into the health insurance they need, treat their illnesses and get them well, all which underpin wellness.

- 5 Nevertheless, while the US policy agenda evolves to fix low rates of health insurance coverage, more careful attention is given to alternatives promoting more than living without illness. Indeed, the health program *Healthy People* and the ACA legislation draw attention to health care as more than an absence of sickness, emphasizing the social determinants of health and wellness. The US's contemporary health policies are evolving in new directions of wellness that in turn extend towards wellbeing and happiness. After all, living well is a happier state of being than getting sick.

2. Differentiating *Wellness* and *Wellbeing*

- 6 Before examining these two concepts, it is worth noting that even the accepted definitions of *health* go beyond referring to personal physical attributes. The constitution of the World Health Organization (WHO), makes the point that “health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (WHO, 2018). Good health is not simply the absence of the malady, as it was traditionally regarded. As with the WHO's definition of health, the term *wellness* refers to more than just the absence of bad health, and *wellbeing* takes the notion several steps further.
- 7 Similar to the WHO, *The Oxford dictionary* defines wellness as “the state of being in good health” and not just the absence of sickness (Oxford University Press, 2018); the definition also insists that wellness can be a concrete and measurable goal. Wellbeing, on the other hand, is defined more extensively than wellness. *The Oxford dictionary* defines it as “the state of being comfortable, healthy, or happy” (Oxford University Press, 2018). The dictionary highlights that both wellness and wellbeing include some value of health, but wellbeing also encompasses comfort and happiness. In addition, synonyms for wellbeing include feelings such as happiness, comfort, prosperousness and welfare (Oxford University Press, 2018). Research, too, expands the scope of wellness and wellbeing to embrace non-traditional health, happiness and other beneficial attributes.
- 8 An introduction to wellness by Professor Anna Kirkland of the University of Michigan explores more deeply the concept. Her article establishes, similar to the Oxford definitions, that wellness is not the management of a current condition, but that wellness is a set of comprehensive, and individual-level choices made well before the occurrence of any such health condition (Kirkland, 2014). Clearly stated: someone who is satisfying wellness is living well and is working towards the prevention of their own disease and disability. The term departs from traditional health because it does not focus on curing anything, but on living well.
- 9 To extend beyond wellness, Professor Ed Diener, considers wellbeing as a more self-actualizing trend. The American psychologist defines wellbeing synonymously with happiness. In his 1984 paper Diener contends that the literature on subjective experiences of wellbeing “is concerned with how and why people experience their lives

in positive ways” (Diener, 1984). Diener also suggests that the positive experiences of happiness, including life satisfaction, are defined by the self. More tangible concepts of health such as comfort and wealth may enhance wellbeing, but are not essential to someone’s view of their own life, and therefore wellbeing, according to Diener (1984). Happiness in relation to wellbeing appears again in a paper about ageing and health from Steptoe *et al.* (2015). They discern three different approaches to subjective wellbeing and its measurement: life evaluation (subjective appraisals), hedonic (personal feelings) and eudemonic (judgments about the purpose of life). Within the second form, hedonic wellbeing, we find emotions such as happiness, sadness and anger (Steptoe *et al.*, 2015) that relate to Diener and Oxford dictionary’s definitions.

- 10 In examining how wellbeing is used in the literature, a 2014 paper entitled “The Metrics of Social Happiness” refers to subjective wellbeing (SWB) as a concept related to happiness. Subjective wellbeing, according to Tay *et al.* (2014), is how people regard their own lives. Of course, such a measure is ‘subjective’ because how one person feels about his or her own life is unique. Any measure of wellbeing on a national level would therefore need to consider commonalities in how that nation’s citizens judge and think about their lives. Despite its anomalous nature, however, wellbeing can be studied and its results utilized to influence social policy formation. A study by Diener and Chan, for example, measures wellbeing and its effect on health and lifespan (2011). They separate subjective wellbeing (SWB) into high subjective wellbeing and low subjective wellbeing. To have high subjective wellbeing means to have high levels of “life satisfaction, absence of negative emotions, optimism, and positive emotions” (Diener and Chan, 2011). Their study does find qualitative positive effects of a high SWB. A more recent study by Diener *et al.* (2017) reviewed similar evidence in reference to the effect of SWB on health. Their conclusion was similar to the 2011 study in that they find that subjective wellbeing affects health but because of the absence of research to determine a causal link between SWB and health and longevity, a quantitative relationship cannot be made (Diener *et al.*, 2017).
- 11 The definitions and observations offered by the literature and research assert a clear distinction between wellness and wellbeing. Making use of these sources, I consider that both concepts come under the umbrella term of health. Wellness is the freedom from illness and contains a lifestyle of prevention. Wellbeing is also wellness, but also includes happiness, which is not explicitly referenced in wellness. Simply put: traditionally, health just meant managing sickness. Wellness has come to mean living well, and wellbeing means living well and enjoying happiness. In essence, concise clear definitions of health, wellness and wellbeing respectively are to get well, live well and be happy.
- 12 An important additional term for understanding the growing attention towards the health of wellness and wellbeing in US health discourse and policy is the Social Determinants of Health (SDOH). The SDOH point out that our medical care is just one of the factors that influences our health. Artiga and Hinton (2018), with the Kaiser Family Foundation (Kaiser), a US health policy analysis and health journalism organization, define the SDOH. The Kaiser article contends that the determinants of our health include the Health Care System as only one of the five determinants of health outcomes (Artiga and Hinton, 2018). The Health Care System is useful to consider but only as the traditional ‘get well’ view of health. Simply getting patients out of sickness had been the sole source of information and main focus of policy until the social determinants

were taken into consideration. According to Artiga and Hinton, in addition to health care, the four determinants of health are: Economic Stability, Neighborhood and Physical Environment, Education, Food and Community and Social Context. Together the five form the SDOH, which help evaluate whether or not people can live healthy lives, that is, wellness. Similar terminology and emphasis also show up internationally. The Organisation for Economic Cooperation and Development (OECD) also focuses on socioeconomic factors such as education and living conditions and how they affect health (Organisation for Economic Cooperation and Development (OECD), 2017).

- 13 Finally, it is helpful to think of health, wellness and wellbeing as similar to the basic needs ranked in Maslow's pyramid (1943). Maslow devised a hierarchy of needs; basic needs, such as food and shelter, form the foundation. If these needs are satisfied, we can build up to personal development. With successful personal development, at the top of the hierarchy we find happiness and self-actualization. The loosely equivalent foundation is the traditional medical system and its emphasis on staying out of sickness: this is the basic need of a nation's health system. It is a foundation that is critical for what rests on it. Wellness is built on this base because it extends traditional health concepts to include a state of being in good physical, mental and social health--living well. This involves more than just the absence of sickness and acknowledges the social determinants that also affect health. Wellbeing is on top of the hierarchy and could be compared to the self-actualization, insofar as it depends on medical health, living well, but also on enjoying happiness and self-fulfillment.

3. Health Policies: Costs and Efficiency

- 14 No matter what sound evidence and beneficial aspirations that policies might develop, their outcomes are going to be heavily dependent on effective resource allocation. A distinguishable feature of the US's health care system is its high financial cost. Below in Chart 1, I use statistics on health expenditure as a percent of gross domestic product (GDP). This compares the amount of health dollars spent on health systems across nations. The chart shows health expenditure as a percent of gross domestic product from 2000 to 2015 for the US and other select OECD countries. In 2015, the US spent 16.8 percent of their GDP on health, shown by the highest dotted line. In terms of GDP, the US spent nearly double the average of other OECD countries (8.8 percent shown by the solid line) and a higher amount than any other OECD country alone (WHO, 2018).

- 15 The high financial expenditure of the United States does not, however, translate to a strong health system. According to The Commonwealth Fund, the US ranked last out of 11 countries in terms of their 2013 overall country ranking (Davis *et al.*, 2014). The report also shows health expenditures per capita in 2011. Overall, there seems to be little direct relation between high or low spending and the ranking of health systems; for example, the UK ranked number one with its health system, but had the second-lowest expenditure per capita. France and Canada both spent approximately half the equivalent of the US's expenditure per capita, but both were ranked poorly (France received 9 out of 11, and Canada 10) (Davis *et al.*, 2014). As shown by The Commonwealth Fund, spending on resources does not equate to good health and a good health system; therefore, factors like on what and how the money is spent must be responsible.
- 16 In the United States, clinical care takes a high proportion of health care spending (National Center for Health Statistics, 2017: 316). Yet a model of health outcomes published in 2010 by the University of Wisconsin Population Health Institute shows that clinical care is not the most important component to health. In fact, they write that clinical care is responsible for 20 percent of our health outcomes. The same model contends that health is influenced 40 percent by social and economic factors such as education and employment (Knickman and Kovner, 2015: 91). These non-clinical factors included in the 40 percent relate directly to the social determinants of health and thus to wellness.
- 17 In American academia, studied factors that contribute to good health are no longer limited to medical-related issues. The factors that are outside the traditional medical perspectives are widely acknowledged in US health policy literature and health discourse. A study in 2011 published in the *American Journal of Public Health* calculates the impact of how non-medical determinants contribute to early mortality in the United States. Through a meta-analysis, the paper estimates the risk of social factors in mortality rates; they estimated that in 2000, 245,000 deaths were linked to low

education, 176,000 linked to racial segregation, 162,000 to low social support, 133,000 to individual-level poverty, 119,000 to income inequality, and 39,000 to community-level poverty (Galea *et al.*, 2011). These causes of early death can be summarized as social factors that are not directly related to the medical system, but are the consequences of economic and social inequities.

- 18 If the factors that contribute to early mortality were addressed, the result would logically bring greater national wellness. A study published by *PLoS ONE* reviews literature on policies to address societal problems similar to those identified by Galea *et al.*, such as income support and community outreach; the study finds evidence that the policies have significant impacts on health outcomes including mortality (Taylor *et al.*, 2016). Although Galea *et al.*'s study does not directly address wellbeing, Taylor *et al.* show that policies that address societal inequalities reduce mortality; and those who live well for longer would likely be happier. Evidence-based studies, such as these on mortality, will hopefully help to bring the message of the importance of wellness to US health policy and communication.

4. Wellness and Wellbeing in National Health Promotion Campaigns and Legislation

- 19 At a national level the health promotion campaign *Healthy People* communicates an emphasis on wellness and how it contributes to health. *Healthy People* is a federal initiative run by the Office of Disease Prevention and Health Promotion (ODPHP) that was started in 1979 to design broad goals and objectives for the country's health (ODPHP, 2018a). *Healthy People* is drafted every ten years through a collaborative effort between the US Department of Health and Human Services, sixteen lead federal agencies, such as the Centers for Disease Control and Prevention (CDC), the Food and Drug Administration, the Department of Education (ODPHP, 2018b), public health experts, and the public (US Department of Health and Human Services [HHS], 2010). The structure of the plan is designed to provide measurable outcomes that all stakeholders in health should focus on in the decade forward. The collaborative effort of *Healthy People* shows a recognition that factors related to good health are complex and that it takes dedication from a diverse range of organizations to influence policy.
- 20 The most recent edition, *Healthy People 2020*, includes more than one thousand objectives divided into 42 topic areas. A new topic area is the Social Determinants of Health, which was only introduced to this 2020 edition of *Healthy People* (US HHS, 2010). Its inclusion shows that health is recognized as being made up of many individuals and community factors. The accountable objectives of the Social Determinants of Health measure factors such as children growing up with employed parents, poverty levels, housing cost burdens, high school graduation rates, children growing up with parents that have served in jail or prison, and voting turnout rates (ODPHP, 2018c). Apart from these factors, the social determinants of health share indicators with many other topic areas, such as adolescent health, access to health services, disability and health, environmental health, early and middle childhood, health communication and health information technology, injury and violence prevention, and nutrition and weight status.

- 21 The objectives included in the social determinants of health also make reference to outcomes that would probably enhance wellbeing; for example, one objective is to provide adolescents with increased access to adults with whom they can discuss serious problems (ODPHP, 2018c). Wellbeing and happiness are not directly mentioned as objectives, but such support for adolescents might reasonably be expected to improve their self-fulfillment. *Healthy People 2020*'s inclusion of such objectives demonstrates that living well and being happy and self-fulfilled are increasingly recognized as important for health. *Healthy People 2020* communicates nationally how to build a society with high levels of health, wellness and wellbeing.
- 22 Data on the *Healthy People 2020* indicators is collected and available on the *Healthy People* website (healthypeople.gov). A March 2014 progress update on the status of *Healthy People 2020*, for example, presents data on 26 Leading Health Indicators. These indicators were chosen from within twelve of the *Healthy People 2020* objectives. At the time of that report the percentage of students to receive a high school diploma within four years of starting high school had increased from 74.9 percent in 2007-2008 to 78.2 percent in 2009-2010 (ODPHP, 2014). Using high school graduation statistics in a health-analysis framework demonstrates how education is accepted as an important to health. Overall, the *Healthy People* initiative, with its interagency cooperation and its inclusion of the Social Determinants of Health, considers health as living well. This consideration represents that stakeholders at the federal level want to project a new framework for health issues.
- 23 Movement towards a nationwide recognition of wellness has also occurred through health policy legislation. Former President Barack Obama, in 2010, signed into law the *Patient Protection and Affordable Care Act* (ACA), a comprehensive legislation to reform the US health and health care systems. Its passing was the largest milestone in American health policy since the 1960s that brought the foundation of Medicare and Medicaid. Within the titles of the ACA were policies designed to accomplish three main goals: expand access to health coverage, contain costs, and improve health system quality and performance (Kaiser, 2013).
- 24 Most importantly, the ACA expanded eligibility of Medicaid, the government health insurance assistance program for low-income people, prohibited the denial of coverage to those with pre-existing conditions, required employers of a certain size to offer health insurance to their employees, and required individuals to carry health insurance or face a financial penalty (Kaiser, 2013). These changes describe the first three titles of the ACA in which the focus was on the health care of getting well.
- 25 The legislation additionally reformed other parts of the health system, including prevention and wellness programs that move the country towards living well. The term wellness appears much more frequently than wellbeing in the ACA; 'wellness' appears 93 times in the 906-page document whereas 'well-being' only appears five times (Office of the Legislative Counsel, 2010). The big difference could show that the term wellbeing is not well appreciated nor understood; but the frequency of wellness asserts the ACA's objective to increase health care coverage and to living well.
- 26 Referring back to the model from the University of Wisconsin Population Health Institute, we know that clinical care only has a 20 percent influence on our health outcomes. The ACA, although it focuses mostly on clinical care and access, also includes policies to develop public health. Within the fourth title, the ACA expands the US's policy agenda on health to include wellness. The title supports wellness by allocating

money and resources to fund, assist and incentive workplace wellness programs. Firstly, a grant fund for small employers allocated \$200 million up to 2015 for grants to eligible employers with fewer than 100 employees that did not offer a wellness program prior to the ACA (Office of the Legislative Counsel, 2010; Public Health Law Center, 2011). To be considered a comprehensive wellness program eligible for funds the program had to include health awareness activities, efforts to maximize engagement among employees, initiatives to alter health harming behavior and efforts to create a supportive working environment (Office of the Legislative Counsel, 2010).

- 27 The second part of the ACA's wellness provisions includes assistance for employers to monitor their wellness programs. Standardized measures of those programs include quantifiable measures such as worker absenteeism, medical costs and productivity. And lastly, the third clause allows employers to offer their employees incentives for participating in the work-based program and meeting certain health standards (Office of the Legislative Counsel, 2010; O.C.A. Benefit Services, 2012).
- 28 In 2013, two years following the enactment of the ACA, the RAND Corporation, sponsored by the US Department of Labor and the US Department of Health and Human Services, issued a report on the wellness programs resulting from the ACA (Mattke *et al.*, 2013). The publication used evidence collected in the RAND Employer Survey conducted nationally of employers with over 50 employees. The report provides follow up on the ability of the ACA to increase wellness through the United States' employer-based health care system. RAND finds that when employees participate in a work wellness program there was an effect on lowering health care utilization and costs of medical care. In fact, across surveyed employers they report an annual yearly average savings of \$157 over non-wellness program participation (Mattke *et al.*, 2013). In terms of other effects of the wellness programs, RAND finds greater changes in terms of absenteeism and worker productivity. Of all employers with wellness programs that were surveyed, 78 percent reported decreased worker absence and 80 percent reported greater productivity (Mattke *et al.*, 2013).
- 29 RAND also reports on their review of the provisions for allowable incentives in wellness programs set out by the ACA. They found that incentives, when used by employers, were found to encourage employees targets for their health. Incentives over \$5 were effective in increasing worker participation in wellness programs (Mattke *et al.*, 2013). Finally, the report did find that those incentives for participation had a small effect on individual outcomes of weight, smoking and exercise (Mattke *et al.*, 2013). The RAND report asserts the important step towards wellness that the ACA made. Wellness programs in the workplace can benefit workers and their employers in terms of measurable standards of living well.
- 30 Apart from supporting wellness in the workplace, the ACA established a nationwide strategy of prevention and wellness. The National Prevention, Health Promotion, and Public Health Council (also known as the National Prevention Council) was established along with a Prevention and Public Health Fund and task force to develop, fund and disseminate evidence-based findings on clinical and community-based strategies of prevention (Kaiser, 2013; Office of the Legislative Counsel, 2010). The National Prevention Council is comprised of representation from twenty US governmental departments and is chaired by the Surgeon General. The departments that form the Council come from inside and outside of the traditional medical view of health, such as

the Department of Health and Human Services, alongside the Department of Education and the Department of Housing and Human Development (US HHS, n.d.).

- 31 The Action Plan of the National Prevention Council was published in June 2012 to outline the implementation of its National Prevention Strategy. The Action Plan centers around four strategic directions including Healthy and Safe Community Environments, Clinical and Community Preventive Services, Empowered People, and Elimination of Health Disparities. The plan also includes seven priorities to meet the goal to “increase the number of Americans who are healthy at every stage of life” (HHS, n.d.). In the 2014 annual report of the National Prevention Council, their latest report, accountable progress and programs are reported on from each of the 17 Council Departments in fulfilling their shared prevention strategy. For example, the Department of Transportation reports progress on their Safe Routes to School program, which funds initiatives to create walkable neighborhoods for kids to arrive and leave from school safely (National Prevention Council, 2014: 23). The Department of Housing and Urban Development reports on their planning committees in many communities that work with partners to incorporate active living and fresh food access into development plans (National Prevention Council, 2014: 39). The Department of Veteran Affairs reports on its initiative to teach veterans healthy cooking through hands-on demonstrations to help intervene in chronic conditions of diabetes and obesity (National Prevention Council, 2014: 39). These three federal departments encourage wellness through activity programs. For example, veterans engaged in healthy cooking demonstrations consciously seek to use their activities to help them cope with their chronic conditions to get well and live well; their activities might also bring them satisfaction and happiness. Overall, collaboration of the National Prevention Council and its members reiterates that the work towards longer living, healthier people involves many stakeholders. This arm of the ACA shows that US policy is considering a more advanced view of health, in terms of prevention, the social determinants and policies for wellness that can also improve wellbeing.

5. Change at State Levels

- 32 In the United States there are many levels at which policies can be enacted and implemented. Due to this separation of powers, federal laws like the ACA can trickle down through policy and political forces to the states in positive and negative ways. A perfect example of this trend can be seen in the Medicaid expansion portion of the ACA. The Act supplied states with money to expand their Medicaid programs to cover individuals with incomes up to 133 percent of the federal poverty line; however, because Medicaid is supported by states, the expansion was challenged on its legality, and the Supreme Court ruled that states had the choice to expand the coverage of their Medicaid programs¹. Even in 2018, only 36 states and the District of Columbia have expanded to adhere to the ACA’s provision, while 14 states have elected not expand their programs (Kaiser Family Foundation, 2019). This example highlights that states have some discretion on policies, and sometimes this can interfere with national goals of public health.
- 33 In other instances, the role of states can support innovation towards a better health system. Within the title of the ACA that focuses on quality, a new institution called the Center for Medicare and Medicaid Innovation (CMMI) was established to encourage

innovative approaches to health systems. CMMI administers an initiative called the State Innovations Model (SIM), which provides states with grants to design, implement, and test ways to transform their health system. SIM grants require states to develop plans that address population health in their own state (Hughes *et al.*, 2015). At the time of writing, 38 states, territories and districts have been awarded with SIM grants and all are working to advance their health care delivery and payment systems in ways that are particular to their areas (Centers for Medicare & Medicaid Services [CMS], 2018a). This innovation can lead to evidence and results that can inform future policies of states and of the nation.

- 34 An example of a state that has received SIM money and has developed and implemented a strategy is the State of Delaware. In February 2013 Delaware was awarded a design grant from CMMI followed by a full grant in December 2014 to test and evaluate their Delaware health care model. One of the Delaware specific objectives of the grant is to support community-based population health programs of ten different organizations (CMS, 2018b). The goal is known as Healthy Communities, and is included as part of the Healthy Neighborhoods committee of the Delaware SIM. The Healthy Neighborhoods committee's 2017 program overview highlights the importance of improving health outcomes by working outside of clinical care. The Delaware SIM, with its five committees, has the goal to put Delaware into the top-five healthiest states in the US (Delaware Center for Health Innovation, 2017). The initiative recognizes that this high goal cannot come without focus on neighborhood determinants of health, as represented through their Healthy Neighborhoods committee. The Delaware SIM initiative is currently ongoing and evaluation of the program is continual. Although the State of Delaware is small, its example shows the power of states to produce pilots of innovation that can benefit public health and wellness. In the future, it will be important to track state level progress of wellness initiatives and committees to understand the changing goals and their effects. The federalist structure of the US allows different interpretations of public policy and in many cases this can help the country move towards an acceptance of the comprehensive nature of health; alternatively, in some cases, that very structure can pose a threat, as it did with the Medicaid expansion.

6. Conclusion

- 35 Non-health care factors and their influence on health are well documented in the American public health literature. The grey literature of US agencies and departments shows that programs of health promotion communicate the importance of the social determinants of health. Legislation shows a certain recognition that 'get well' medical care alone is not sufficient to ensure a healthy population that lives well. The status quo of American health policy, however, still has a preeminent concentration on medical health care and also on the insurance market. American payment systems and insurance markets typically do not promote wellness. Traditionally, doctors and service providers are paid by the quantity of services they provide, rather than the quality of wellness that their patients enjoy. Doctors also might favor excessive testing as it provides a safety net against their own liability or malpractice (Health Affairs, 2012). The SIM grants, with their focus on payment reform and uniting all determinants of health, show a shift from a medical emphasis to wellness emphasis at the state levels. In

all, the federal grants given to states like Delaware highlights that national policy makers now understand that medical get-well care is not enough to improve our county's medical health, and that focus on living well is essential.

- 36 There have been many pushes to change how we view health in the United States. Health promotion campaigns communicate what good health is and how to achieve it. Academic research has confirmed the importance of the social determinants of health, and other wellness factors. Legislation has incorporated academic research findings into policy. An emphasis on health promotion and a change of incentives could move a system from its narrow focus on traditional medical health care. The shift in policy is to promote health with a focus on wellness, which may also promote wellbeing. Wellbeing is equated to life satisfaction and happiness and although studies show its importance, they are unable to directly quantify its relationship to good health and longevity. The lack of quantitative evidence of wellbeing may be a reason why US health policy has stayed away from the topic. However, the new attention to wellness is likely to have positive effects on the wellbeing of those that receive benefits. Many barriers also still exist to prevent wellness and wellbeing policies from becoming law. A major problem in the United States is still the inability of a lot of people to get affordable access to even the most basic medical care they need. Even with recent improvements we have nowhere near the universal health coverage that many other countries enjoy. The resistance to the expansion of Medicaid in many US states shows the political barriers preventing more universal coverage access around the country. In addition, policy proposals are subject to the complications of the political processes that review, revise, adapt and amend all potential legislative efforts. For example, in 2012 Congress severely cut the Prevention and Public Fund, by \$6.25 billion over nine years, and the fund was later cut even more in 2016, ultimately reducing the reach of supported health programs (American Public Health Association (APHA), n.d.; Yeager, 2018). If politics regains the health care and wellness agenda of the ACA, legislation can be worked to increasingly provide health care to support more Americans. And only after adequately addressing the problem of universal health care access to Americans, can and should policy focus on not only getting well, but on living well and more fully enjoying health all the way up to happiness.

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NOTES

1. Additional information on the Supreme Court decision on the Medicaid Expansion available from the Center on Budget and Policy Priorities (CBPP, 2013)

ABSTRACTS

A population's health is contributed to by many factors outside of the clinical setting. American literature and research are asserting the Social Determinants of Health, while terms like wellness and wellbeing are also important. The discourse between wellness and wellbeing show they are both components of health, but wellbeing relates to subjective happiness. The United States health care system spends a lot of money, compared to other countries, showing a skewed allocation of resources. As the United States recognizes a broader definition of health to include wellness and wellbeing, national health promotion and legislation represent this. Policies concerning wellness and health prevention are of particular importance in legislation of the *Patient Protection and Affordable Care Act of 2010*, for example. The focus of American health policy cannot, however, turn away from the more fundamental problem that there are many Americans without health insurance who are unable to get or pay for the clinical care they need. In moving policy forward, more quantitative information and political dedication would help wellness and wellbeing along with health care come onto the health policy agenda.

La santé d'une population est influencée par de nombreux facteurs extérieurs au milieu clinique. La littérature ainsi que la recherche américaine mettent en avant les déterminants sociaux de la santé, tandis que des termes comme « Wellness » et Bien-être sont également importants. Le

discours entre « Wellness » et Bien-être montre que tous les deux sont des composants de la santé, mais que le Bien-être est lié au bonheur subjectif. Le système de santé des États-Unis est très coûteux, par rapport à ceux d'autres pays, ce qui se traduit par une allocation asymétrique des ressources. Les États-Unis définissent de manière plus large la santé pour inclure « Wellness » et Bien-être et cela se reflète dans la promotion de la santé et la législation nationale. Par exemple, les politiques concernant « Wellness » et la prévention de la santé sont importantes pour la législation de la loi *Patient Protection and Affordable Care Act of 2010*. La politique de santé américaine ne peut cependant pas faire l'économie de se pencher sur le problème le plus fondamental, à savoir, le grand nombre d'Américains sans assurance maladie, incapables d'obtenir ou de payer les soins cliniques dont ils ont besoin. En faisant avancer les politiques, plus d'informations quantitatives et de dévouement politique pourraient contribuer à améliorer « Wellness » et Bien-être de même que les soins de santé qui viennent d'être inscrits au programme de la politique de santé.

INDEX

Mots-clés: promotion de la santé, politique américaine de la santé, déterminants sociaux de la santé, facteurs non cliniques, facteurs communautaires, wellness, bien-être

Keywords: health promotion, American health policy, the Social Determinants of Health, non-clinical factors, community factors, wellness, wellbeing

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