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Original article

# Getting serious about the social determinants of health: new directions for public health workers

**Dennis Raphael**[1]

**Abstract:** International interest in the social determinants of health and their public policy antecedents is increasing. Despite evidence that as compared to other wealthy nations Canada presents a mediocre population health profile and public policy environments increasingly less supportive of health, the Canadian public health gaze is firmly – and narrowly – focused on lifestyle issues of diet, physical activity and tobacco use. Much of this has to do with Canada being identified as being driven by a liberal political economy, a situation shared with a cluster of other developed nations. Reasons for Canada's neglect of structural and public policy issues are explored and ways by which public health workers in Canada and elsewhere can help to shift policymakers and the general public's understandings of the determinants of health are outlined. (Promot Educ 2008;15(3): 15-20)

*Key words:* social determinants, health policy, welfare state, health promotion

**Key Points**

- **Despite Canada's reputation in public health theory, actual practice that addresses the social determinants of health is rare.**
- **Much of this is due to Canada's political economy being dominated by market sector interests.**
- **Public health's role in shaping health positive public policies involves education and knowledge dissemination.**
- **Such activities should serve to support social and political movements in support of health.**

## Introduction

Renewed interest in the social determinants of health in Canada and other nations – best illustrated by the WHO's Commission on the Social Determinants of Health (CSDH) (1) – represents yet another cycle of recognition of the importance of structural determinants of health that began in earnest in the 1850s with the writings of Fredrich Engels (2) and Rudolph Virchow (3). For Canadian – and other – public health workers, the calls for renewed focus on early life, education, employment and working conditions, food security, health care services, housing, income and its distribution, social safety net, social exclusion, and unemployment and employment security (4) produce a déjà vu experience recalling the *Ottawa Charter*'s prerequisites of health: peace, shelter, education, food, income, stable eco-system, sustainable resources, social justice, and equity (5).

It should also provoke recollections of numerous Canadian reports and documents, all of which have had impacts upon public health around the world (6). These include *A new perspective on the health of Canadians* (7), *Achieving health for all* (8), Health Canada's *Taking action on population health* (9), and the *Population health template* (10) among others. A new volume on health promotion in Canada summarizes these developments and their impacts upon public health activities elsewhere (6).

Just as was the case in 1986 with the release of the *Ottawa Charter* and the *Achieving health for all* report, the CSDH has generated Canadian governmental and institutional activity (11,12). But now with the benefit of hindsight, it is clear that action upon strengthening the social determinants of health following these 1986 statements was restrained by Canada's joining the UK, USA, New Zealand, and Australia in a neo-liberal resurgence in public policy approaches that served to effectively squash attempts to restructure society in favour of health (13).

## Looking back and looking forward

Now some 20+ years later in the midst of neo-liberal inspired economic globalization, free trade agreements, and continuing government withdrawal from social provision, public health workers in Canada and elsewhere are again being urged to identify and modify the structural determinants of health whose decay

1. School of Health Policy and Management, York University, Canada. Correspondence to: Dennis Raphael, 4700 Keele Street, Toronto, Ontario. (draphael@yorku.ca)
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during this interim is evident (14). To this end, the Canadian Public Health Agency has established a National Coordinating Centre on the Determinants of Health at St Francis Xavier University in Nova Scotia to facilitate such activities (15). How likely are public health workers to succeed in these efforts? What can we take from the experiences of 1986 to produce activities more likely of success?

The renewed focus on social determinants of health in Canada as exemplified by numerous volumes on the topic (4,12,16), participation in the CSDH (1), and national (17) and regional initiatives (18–20) can be traced to efforts by researchers to identify and act upon the specific exposures by which members of different socio-economic groups come to experience varying degrees of health and illness (21). While it was well documented that individuals in various socio-economic groups experienced differing health outcomes, the specific factors and means by which these factors led to illness remained to be identified.

It is no accident that the term *social determinants of health* made its contemporary appearance in a UK volume during the Thatcher era concerned with policy, social organization, and health (22). The concept struck a responsive chord in a Canada which not only had a rich tradition of health promotion and population health activity (6,23) but had also experienced an extended period of increases in income and wealth inequalities (24,25), governmental withdrawal from social provision (26,27), and cuts to the social safety net (28,29).

Certainly, this renewed discussion of social determinants of health is a vast improvement over the dominant public health paradigm with its activities focused on the holy trinity of risk of tobacco use, diet, and physical activity (30). It also represents an approach more consistent with the empirical evidence concerning the determinants of individual and population health – a point Health Canada *and* the CPHA have been advancing for over 20 years (10,31).

But this renewed focus on the social determinants of health – especially in light of the policy failures of the last two decades – raises another important question that is infrequently considered by public health workers in Canada: *What are the political and economic determinants of the social determinants of health?* (32). Income and its distribution, the quality of early life, food and housing security – as examples – do not exist in a vacuum. The quality of these social determinants of health is itself shaped by political, economic, and social forces that differ by nation, region, and municipality (33,34).

## The political economy of the social determinants of health

It is becoming increasingly apparent that the quality of numerous social determinants of health such as early childhood, employment security and working conditions, and the social safety net is predicted by whether a nation is identified as a liberal, conservative, or social democratic political economy as described by Gosta Esping-Andersen (35,36).

Nations with what is termed a liberal political economy such as Australia, Canada, Ireland, New Zealand, the UK, and the USA have historically seen relatively less government action in support of the social determinants of health; nations with social democratic political economies such as Denmark, Finland, Norway, and Sweden much more so. Nations with conservative political economies such as France, Germany, and the Netherlands fall in the middle (34).

Canadian sociologists Saint-Arnaud and Bernard provide a narrative and graphic that succinctly sums up how these differences in political economy come to be related to the quality of the social determinants of health (37). Figure 1 lays out the fundamental characteristics of the varying forms of the welfare state in wealthy industrialized nations.

Of particular interest are their guiding principles and dominant institutions. Canada is a liberal welfare state (38). Liberal welfare states provide the least support and security to their citizens. Canadians consider their welfare state to be much superior to that of the USA, but when viewed within an international perspective, Canada's approach is closer to that of the USA than to European welfare states where poverty levels are lower and greater value is placed upon the economic and social security of citizens.

Within liberal welfare states the dominant ideological inspiration is that of liberty which leads to minimal government intervention in the workings of the marketplace (37). Indeed, such interventions are seen as providing a disincentive to work, thereby breeding "welfare dependence". The results of this ideological inspiration are the meagre benefits provided to those on social assistance in Canada, weak legislative support for the labour movement, undeveloped policies for assisting those with disabilities, and a general reluctance to provide universal services and programmes. Programmes that exist are residual, meaning they exist to provide the most basic needs of the most deprived. Canada, the USA, the UK, and Ireland are the best current exemplars of this form of the welfare state.

Critical social scientists have argued that these liberal welfare states and their ideological characteristics represent the interests of those allied with the central institution of these nations: the market (34,39). It is not an accident that these liberal welfare states have the greatest degree of wealth and income inequality, the weakest safety nets, and the poorest population health (33). These states are prone to cater to the well-off in society who either have interests in the business

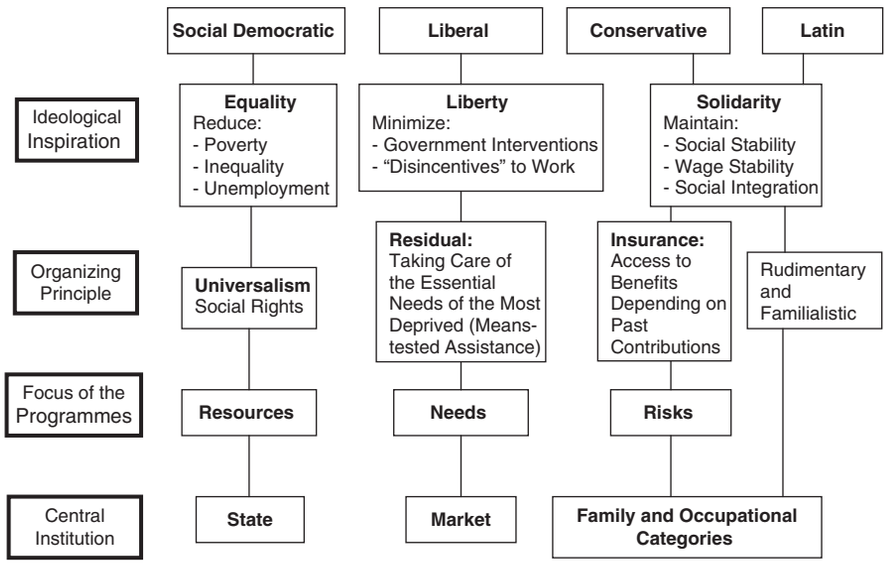


Figure 1. **Ideological variations in forms of the welfare state**
*Source*: Saint-Arnaud and Bernard (37, Figure 2, p. 503)

sector or have come to believe that their interests are best represented by this sector. And it is the business sector in Canada that has most vociferously opposed policies that would reduce poverty, strengthen the social safety net, and improve the lives of the most insecure in Canadian society (27).

The opposite situation is seen among social democratic welfare states. As difficult as it may be for Canadians – and others – to imagine, the ideological inspiration for the central institution of these nations – the State – is the reduction of poverty, inequality, and unemployment. Rather than being concerned with governments meeting the basic needs of the most deprived, the organizing principle here is universalism and providing for the social rights of all citizens.

Denmark, Finland, Norway, and Sweden are the best exemplars of this form of the welfare state. Governments with social democratic political economies are proactive in identifying social problems and issues, and strive to promote economic and social security for their citizens. The outcome of this form of the welfare state has been the virtual elimination of poverty, the striving for gender and social class equity, and the regulation of the market in the service of citizens. The commitment to these principles and the converting of these principles into public policy action can be readily discerned through a review of these nations' public statements and related documents available at government websites (40–45).

Even the conservative (e.g. France, Germany, the Netherlands) and Latin welfare states (Greece, Italy, Portugal) provide superior economic and social security to their citizens than do liberal welfare states (36,46). The ideological inspiration of maintaining social stability, wage stability and social integration is accomplished by providing benefits based on insurance schemes geared to a variety of family and occupational categories. These well-organized benefits schemes are oriented towards the primary wage earners with rather less concern for promoting gender equity than is the case among social democratic nations.

A broad portrait of Canada's place in this world of welfare can be seen by examining its spending on social expenditures. Canada for example, spends 18% of its GDP on social expenditures (47). This figure is higher than for the USA (15% of GDP total social expenditure) but very low in relation to the social democratic (Denmark, 29%; Norway, 24%; Sweden, 29%, and Finland, 25%) as well as conservative (France, 28%; Germany, 27%; Belgium, 27%; and Switzerland, 26%) nations – among others.

Canada is ranked 24th of 30 OECD nations in overall social spending (47). Canada spends only about 5% of GDP on pensions (rank 26th of 30 OECD nations), 0.9% on families (also ranked 26th of 30), and 0.8% on incapacity or disability benefits (ranked 27th of 30). The cluster of nations identified as liberal political economies – Australia, Ireland, New Zealand, the UK, and the USA show similar profiles (47).

Type of political economy determines societal receptiveness to the concept and policy implications raised by a social determinants of health approach (48). Consider the difficulties Canadian public health workers – and those in other liberal political economies – experience having these broader living conditions-related issues addressed in Canadian legislatures governed by neo-liberal-oriented political parties (49–51). This is not a problem of evidence, it is a problem of political will (32).

## Public health roles: educating the public, health professionals, and policymakers

There are roles that public health workers can play – in addition to their day-to-day efforts to promote health – in promoting healthy public policy in areas related to the social determinants of health. These activities will be especially important – and probably the most contentious – in nations operating under liberal political economies.

These roles are focused on educating and knowledge transmission. Such activities will not by themselves lead to positive public policy in support of the social determinants of health but will clearly assist other sectors who can be more actively engaged in public policy advocacy. The ultimate goal of these activities however – whether we wish to state it publicly or not – is building the political supports by which public policy in support of the social determinants of health can be implemented.

### Presenting the solid facts

In Canada and other nations governed by liberal political economies, the public remains woefully uninformed about the social determinants of health (52–54). The population has also been subject to continuous messaging as to the benefits of a business-oriented laissez-faire approach to governance (13). What this messaging has not included are the societal effects of this approach: increasing income and wealth inequality; persistent poverty; and a relatively poor population health profile (34). These effects are profound and objectively influence – for the worse – the health and well-being of a majority of the population (36). The media have been especially negligent in reporting these issues (55,56).

There are hundreds – if not thousands – of Canadians and citizens of other nations whose occupations are concerned with public health. These workers could take advantage of the citizenry's continuing concern with health and the wealth of evidence of the importance of the social determinants of health to begin offering an alternative message to the dominant biomedical and lifestyle discourse. At a minimum public health workers can carry out – and publicize the findings from – critical analysis of the social determinants of health and disease. This is not a question of being subversive – it is rather a simple matter of information and knowledge transfer.

There is no shortage of areas in which public health workers could engage: social determinants of health such as poverty, housing and food insecurity, and social exclusion appear to be the primary antecedents of just about every affliction known to humankind (57,58). My short list of such afflictions includes coronary heart disease, type II diabetes, arthritis, stroke, many forms of cancer, respiratory disease, HIV/AIDS, Alzheimers, asthma, injuries, death from injuries, mental illness, suicide, emergency room visits, school drop-out, delinquency and crime, unemployment, alienation, distress, and depression. Examples of such analyses and critiques of the dominant paradigms are available (59,60).

### Telling stories

Public health workers can shift public, professional, and policymakers' focus on the dominant biomedical and lifestyle health paradigms to a social determinants of health perspective by collecting and presenting stories about the impact social determinants of health have on people's lives. Ethnographic and qualitative approaches to individual and community health produce vivid illustrations of the importance of these issues for people's health and well-being (61). And such volumes are becoming more available in Canada (62–64). There is some indication that policymakers – and certainly the media – may be responsive to such forms of evidence (65). In Canada, such research clearly constitutes a small proportion of public health activities (66).

There is increasing recognition of the importance of community-based action – such as community needs assessment – that applies these approaches (67,68). But frequently, these *activities* are narrow and appear not willing to allow citizens to raise issues of public policy concerned with income distribution, employment and labour issues, and fundamental questions of citizen participation in governmental priorities and actions. Such activities can be a rich source of insights about the mainsprings of health and means of influencing public policy. Such a perspective allows community members to provide their own critical reflections on society, power, and inequality. At a minimum these approaches allow the voices of those most influenced by the social determinants of health to be heard and hold out the possibility of their concerns being translated into political activity on their part and policy action on the part of health and government officials. Ultimately, the end of such activities should be the creation of social movements in support of health, of which the People's Health Movement is but one example (69).

### Providing support for policy action

The final role is the most important but potentially the most difficult: supporting policy action in support of health. And implicit in such a course of action is recognizing the important role politics play in these activities (70). There is increasing evidence that the quality of any number of social determinants of health within a jurisdiction is shaped by the political ideology of governing parties.

It is no accident that nations where the quality of the social determinants of health is high have had greater rule by social democratic parties of the left. Indeed, among developed nations, left cabinet share – that is the percentage of the governing cabinet that are members of social democratic parties such as Labour in the UK, Social Democrats in Sweden, or the New Democrats in Canada – in national governments is the best predictor of child poverty rates which itself is associated with extent of government social transfers (71). Nations with a larger left cabinet share from 1946 to the 1990s have the lowest child poverty rates and highest social expenditures; nations with less left share have the highest poverty rates and lowest social expenditures. Canada, like the other liberal nations of Ireland, the UK, and the USA is among the lowest nations in left federal cabinet share (0%) and among the highest in child poverty rates (15%) in the 1990s (providing a poor poverty standing of 19th of 26 OECD nations).

It has also been documented that poverty rates and government support in favour of health – the extent of government transfers – is higher when popular vote is more directly translated into political representation through proportional representation (72). Canada – and the other liberal political economies with the exception of Ireland and New Zealand – does not have proportional representation – the lack of which is associated with higher poverty rates and less government action in support of health (72). Proportional presentation is important because it provides for an ongoing influence of left-parties regardless of which party forms the government.

## Towards the future

Where does this knowledge of the role of politics in shaping the quality of the social determinants of health leave public health workers? Public health workers are both government employees as well as citizens imbued with certain political rights. Clearly, advocacy in support of specific political parties is not on the agenda in public health units' day-to-day activities. However, providing information on how public policies impact the social determinants of citizens' health would seem to be an appropriate public health activity.

### Public health agency action

And there are public health units in Canada that have taken these steps of documenting the quality of numerous social determinants of health in their local jurisdiction (18–20). Another task they have taken on is facilitating inter-sectoral collaboration on addressing the social determinants of health – a key step in raising these issues for possible policy action (11). The problem is that there are so few examples of these activities. They do however provide a model of what is possible.

Further support for such a role can be seen in the mission statement of the National Coordinating Centre for Determinants of Health (NCC-DH) recently established by the Canadian Public Health Agency (73).

> The aim of the NCC-DH is to increase the knowledge base and influence practice at all levels in public health and to increase partnerships and develop inter-sectoral collaborations to address specific determinants of health or combinations of those determinants.
>
> The mission of the NCC-DH is to engage the participation of researchers, policy-makers, health practitioners and the public in moving knowledge about the broad determinants of health into policy and practices to achieve social justice and health for all (p. 1).

Yet, the reality is that only a handful of public health authorities across Canada have taken on these kinds of activities (74–76). A cursory review of any health unit website across Canada is much more likely to find information and programmes about diet, tobacco and alcohol use, and physical activity than a presentation of the importance to Canadians of the social determinants of health. Clearly, the NCC-DH has its work cut out for it.

### Health associations' action

Another potential means of action for public health workers on the social determinants of health is through association action. The Canadian Public Health Association (CPHA) has produced numerous papers on determinants-related issues that have sadly remained on the CPHA website with little take-up by health units (31). The Registered Nurses Association of Ontario (77), the Canadian Nurses Association (78), and the Association of Ontario Health Centres (79) have also produced clearly stated policy documents that raise these issues and the need for action.

### Political engagement

Public health workers are also citizens who can vote and support particular political parties between and during political campaigns. Canadians are not a particularly politicized people and there is no reason to think that public health workers are much different than the average Canadian (80). In 2003 only 3% of Canadians volunteered for a political party, 6% participated in a demonstration or march, 21% attended a public meeting, 26% searched for political information, and 27% signed a petition. The importance of the social determinants of health to their employment goals – better health for all – should serve as a spur to increase such participation among public health workers.

## Conclusion

A political economy approach recognizes that social-democratic-oriented public policies create the conditions necessary for health. These conditions include equitable distribution of wealth and progressive tax policies that create a large middle

class, strong programmes that support children, families, and women, and economies that support full employment: '[F]or those wishing to optimize the health of populations by reducing social and income inequalities, it seems advisable to support political forces such as the labour movement and social democratic parties which have traditionally supported larger, more distributive policies' (31, p. 490).

And while it is apparent that Canadian public policy has been moving more and more towards a neo-liberal US-type model, reversals are possible. Indeed, New Zealand took a similar neo-liberal course during the 1990s, but has now reversed direction. Ideologies are malleable and national social policies can be changed.

For over 10 years I have been attempting to understand the growing gap between Canadian public health rhetoric and action. My analysis of developments in wealthy developed nations indicates that public health activities operate within the confines of the dominant political and economic discourses within a society (48). In Canada the rise of neo-liberal approaches to governance has made concern with the social determinants of health not only unpopular among governing circles but actually threatening to agency funding and individual health promoters' career prospects.

Nevertheless, the best means of promoting health through a social determinants of health perspective would involve agencies, organizations, and even government employees navigating the difficult task of informing citizens about the political and economic forces that shape the health of a society.

At a recent Roundtable on the Determinants of Health sponsored by the NCC-DH held in Toronto, one health worker suggested that every public health nurse should be charged with informing their clients not only of the importance of eating fruits and vegetables, exercising, and washing their hands frequently, but also communicating that the primary factors that shape their health are their living conditions – and what they can do to improve them!

A more practical first step would see public health units and their workers taking on the role of communicating the emerging knowledge about the social determinants of health to their professional colleagues, political masters, and the general public. There seems to be no obvious reason – considering the available evidence on their importance to health – for not using the same tools to address the social determinants of health as were used to combat the tobacco and obesity epidemics: information sharing, social marketing, and policy advocacy.

Once public health has done its task of educating these constituencies, each and any of these groups could then choose to consider political and other means of addressing these issues. A few public health units across Canada have taken up the challenge (81). This all seems a rather daunting task, but one that holds the best hope of promoting the health of citizens in Canada and elsewhere.

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