

Recognizing the Political Barriers to a Healthy Inclusive Society:

The Case of the Social Determinants of Health

Dennis Raphael, York University, Toronto, Canada

Abstract

Social exclusion – the flip side of social inclusion -- has been recognized as a prime social determinant of health. Considering Canada's record as a leader in the development of health promotion and population health concepts, it would be expected that policymakers would be especially interested in applying what is known about social exclusion and other social determinants in order to promote the health of Canadians. The reality is that not only do many government policymakers appear uninterested in applying these concepts, they seem to be actually working to weaken these social determinants of health. And sadly, voices from the sectors that should be most expected to champion the importance of these concepts – the public health and health care communities – are frequently silent on these issues. This presentation speaks to the political and economic forces that make application of a social inclusion agenda – part of a broader social determinants of health framework -- difficult if not impossible. The argument is made that improving the health of Canadians will involve identifying and challenging the forces that oppose a social inclusion agenda.

Recognizing the Political Barriers to a Healthy Inclusive Society: The Case of the Social Determinants of Health

Any discussion of social inclusion must consider the process that leads to citizens being excluded from participation in the daily activities normally expected of those living in a democratic society. I make the case that this process of social exclusion can be viewed as an important determinant of both individual and population health. As such, understanding of how this process may be reversed or ameliorated can draw upon knowledge accumulated about policy responses to other social determinants of health.

In the paper I argue that recent experiences in having governmental policy makers address these kinds of issues does not bode well for the building of an inclusive, healthy Canada. This is surprising as Canada has been seen as a leader in advancing concepts of health promotion, population health, and social determinants of health. But these difficulties can be understood in light of the ascendance of neo-liberal ideology and the associated weakening of the welfare state. Such ideology is fundamentally at odds with what is known about supporting health by strengthening the social determinants of health. Building an inclusive agenda that supports the social determinants of health will require recognition of these forces and educating the public about the health consequences of these regressive social policies.

Social Determinants of Health

Social determinants of health are the non-medical and non-lifestyle factors that influence population health (Marmot & Wilkinson, 2000). The *Ottawa Charter for Health Promotion* identifies *prerequisites for health* of peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity (World Health Organization, 1986). Health Canada's *determinants of health* -- only some of which are social determinants -- are income and social status, social support networks, education, employment and working conditions, physical and social environments, biology and genetic endowment, personal health practices and coping skills, healthy child development, and health services (Health Canada, 1998). A UK working group identifies *social determinants of health* of the social [class health] gradient, stress, early life, social exclusion, work, unemployment, social support, addiction, food, and transport (Wilkinson & Marmot, 1999).

The recent Canadian conference *Social Determinants of Health Across the Life Span: A Current Accounting and Policy Implications* brought into sharp relief the links between social policy and population health (Raphael & Curry-Stevens, 2003). Speakers described the state of ten social determinants of health -- early life, education, employment and working conditions, food security, health services, housing, income and income distribution, social exclusion, the social safety net, and unemployment and job insecurity -- across Canada and the mechanisms by which these determinants influence population health.

Social exclusion – the flip side of social inclusion -- has been recognized as a prime social determinant of health. The concept of social exclusion provides a useful means of understanding how various social determinants of health such as low income, poor housing, and food are interrelated and come to affect health. The concept of social exclusion also describes an overall process by which Canadians are adversely affected by governmental social and economic policies and other societal processes. Contemporary definitions of social exclusion include:

Social exclusion is defined as a multi-dimensional process, in which various forms of exclusion are combined: participation in decision-making and political processes, access to employment and material resources, and integration into common cultural processes. When combined they create acute forms of exclusion that find a spatial representation in particular neighbourhoods (Madanipour, Cars, & Allen, 1998).

Exclusion processes are dynamic and multidimensional in nature. They are linked not only to unemployment and/or to low income, but also to housing conditions, levels of education and opportunities, health, discrimination, citizenship and exclusion in the local community.(European Social Policy White Paper, 1994)

Social exclusion is a process by which people are denied the opportunity to participate in civil society; denied an acceptable supply of goods or services; are unable to contribute to society, and are unable to acquire the normal commodities expected of citizens. All of these elements occur in tandem with the material deprivation, excessive psychosocial stress, and

adoption of health threatening behaviours shown to be related to the onset of, and death from, chronic disease.

The value of the concept is that it recognizes that exclusion from society is something that happens to people as a result of societal change and government policy rather than a direction freely chosen by individuals.(Shaw, Dorling, & Davey Smith, 1999) The processes that lead to social exclusion include economic change such as increased unemployment or widespread job insecurity. It also includes demographic changes such as an aging population or single parent families, changes to welfare programs such as cuts and withdrawals, discrimination and systematic exclusion from societal participation, and specific processes of geographical segregation and isolation of certain groups such as those with low income. Government policies are especially important in either increasing or decreasing the extent of social exclusion within a society.

Considering Canada's record as a leader in the development of health promotion and population health concepts, it would be expected that policymakers would be especially interested in applying what is known about social exclusion and other social determinants in order to promote the health of Canadians. The reality is that not only do many government policymakers appear uninterested in applying these concepts, they seem to be actually working to weaken these social determinants of health. And sadly, voices from the sectors that should be most expected to champion the importance of these concepts – the public health and health care communities – are frequently silent on these issues.

The Example of Heart Health in Ontario

I recently reviewed the literature on the social determinants of heart disease for the North York Heart Health Network. *Inequality Is Bad for Our Hearts: Why Low Income and Social Exclusion are Major Causes of Heart Disease in Canada* (Raphael, 2001) drew upon recent European work concerning social exclusion to place income within a framework of how government and social policies reduce opportunities for citizens to participate in societal activities (Byrne, 2000; Madanipour et al., 1998; Social Exclusion Unit, 2001).

In the process of carrying out this effort, I became aware of not only the burgeoning literature on the societal determinants of CVD from the UK and other European nations, but also identified the few pockets of income-related health research in Canada and the USA. The review

also found increasing skepticism concerning the value of the lifestyle approach to CVD prevention -- which is dominant in Canada -- by many health specialists (Ebrahim & Davey Smith, 2001; Fitzpatrick, 2001; Jarvis & Wardle, 1999; O'Loughlin, Paradis, Gray-Donald, & Renaud, 1999; Taubes, 2001).

Of particular importance to those working to bolster social inclusion, are the diverse reactions of various health and community sectors to the review's conclusion that societal factors -- not lifestyle choices -- are the primary determinants of the incidence of, and mortality from, CVD. These responses ranged from the enthusiastic to the hostile. Overall, the responses to the report by various sectors can be summarized as follows: Enthusiastic: social development/social welfare organizations, anti-poverty community groups, faith communities; Ambivalent and guarded: public health units in Ontario, lifestyle-oriented health promoters, illness-oriented foundations such as the Heart and Stroke Foundation, the media; and Unfriendly: Ontario Ministry of Health/Long-Term Care and the Ontario Heart Health community. The public health and health care sectors are well aware of these findings. These reactions led to my thinking that the main barriers to acting upon these issues was not lack of knowledge but rather ideological and political issues.

Explaining the Gap Between Knowledge and Action

Nowhere is the gap between knowledge and action more clearly seen than in the Kirby, Mazankowski, and Romanow reports on health care (Kirby, 2002; Mazankowski, 2001; Romanow, 2002). All three reports detail the importance of social determinants of health, yet each limits their recommendations to exhorting Canadians to improve their diets, be physically active, and refrain from tobacco use.

I believe the main cause of the gap between knowledge and action on the social determinants of health is the conflict between progressive health policy and forces driving the erosion of the welfare state (Raphael, in press-a). Social determinants of health such as equitable income and wealth distribution and strong social service infrastructures are deteriorating as a result of policies driven by the ascendance of corporate power associated with corporate globalization (Laxer, 1998). Transnational corporations actively oppose reforms associated with the welfare state in order to maximize profits by reducing labour costs, limiting government regulation, and using their concentrated wealth and power to influence policymaking (Banting,

Hoberg, & Simeon, 1997; McBride & Shields, 1997; Teeple, 2000).

Neo-liberalism – by emphasizing the market as the arbiter of societal values and resource allocations -- is the justifying discourse for this process (Coburn, 2000; Coburn, 2001; Coburn, 2003). Neo-liberal political and economic policies foster income and wealth inequalities, weaken social infrastructure, and oppose labour legislation (Zweig, 2000). Its emphasis on reducing income and corporate taxes benefits the wealthy and creates increasing social and economic inequality (Raphael, in press-a).

Towards the Future

Can anything be done to resist deteriorating political, economic, social and health conditions given contemporary globalization? Do governments have little choice but to become complicit in these processes? In Europe, concerted public health and community efforts have influenced policymaking that limits economic, social, and health inequalities (Mackenbach & Bakker, 2002). The policy directions undertaken by nations such as Sweden and Finland are two such examples (Agren & Hedin, 2002; Finnish Ministry of Social Affairs and Health, 2001).

Such actions will not be successful in Canada unless the political component of health policy is clearly acknowledged and the forces that oppose the welfare state and economic and social fairness are recognized and confronted (Raphael, in press-b). The faith, health, labour, social development, and social justice sectors have shared interests that are relevant to the health of Canadians.

Political and economic forces shape the quality of various social determinants of health. Population health theory and research identifies the processes by which these social determinants influence health. The best means of promoting health therefore involves Canadians addressing the political and economic forces that first created the Canadian welfare state and are now moving to destroy it.

References

- Agren, G., & Hedin, A. (2002). *The new Swedish public health policy*. National Institute of Public Health. Retrieved March 1, 2003, from the World Wide Web: http://www.fhi.se/pdf/roll_eng.pdf
- Banting, K., Hoberg, G., & Simeon, R. (Eds.). (1997). *Degrees of freedom: Canada and the United States in a changing world*. Montreal, Canada: Queens McGill University Press.
- Byrne, D. (2000). *Social Exclusion*. Philadelphia: Open University Press.
- Coburn, D. (2000). Income inequality, social cohesion and the health status of populations: The role of neo-liberalism. *Social Science & Medicine*, 51(1), 135-146.
- Coburn, D. (2001). Health, health care, and neo-liberalism. In D. Coburn (Ed.), *Unhealthy times: The political economy of health and care in Canada* (pp. 45-65). Toronto, Canada: Oxford University Press.
- Coburn, D. (2003). *Beyond the income inequality hypothesis: Globalization, neo-Liberalism, and health inequalities*. Toronto: Department of Public Health Sciences.
- Ebrahim, S., & Davey Smith, G. (2001). Exporting failure: coronary heart disease and stroke in developing countries. *International Journal of Epidemiology*, 30, 201-205.
- European Social Policy White Paper. (1994).
- Finnish Ministry of Social Affairs and Health. (2001). *Government resolution on the Health 2015 public health programme*. Ministry of Social Affairs and Health. Retrieved March 1, 2003, from the World Wide Web: <http://www.vn.fi/stm/english/eho/publicat/health2015/summary.htm>
- Fitzpatrick, M. (2001). *The Tyranny of Health: Doctors and the Regulation of Lifestyle*. London: Routledge.
- Health Canada. (1998). *Taking action on population health: A position paper for Health Promotion and Programs Branch staff*. Health Canada. Retrieved March 1, 2003, from the World Wide Web: http://www.hc-sc.gc.ca/hppb/phdd/pdf/tad_e.pdf
- Jarvis, M. J., & Wardle, J. (1999). Social patterning of individual health behaviours: the case of cigarette smoking. In R. G. Wilkinson (Ed.), *Social Determinants of Health* (pp. 340-255). Oxford, UK: Oxford University Press.
- Kirby, M. J. (2002). *The health of Canadians: The federal role*. Ottawa: Standing Senate Committee on Social Affairs, Science and Technology.
- Laxer, J. (1998). *The undeclared war: Class conflict in the age of cyber-capitalism*. Toronto, Canada: Viking.
- Mackenbach, J., & Bakker, M. (Eds.). (2002). *Reducing inequalities in health: A European Perspective*. London UK: Routledge.
- Madanipour, A., Cars, G., & Allen, J. (1998). *Social Exclusion in European Cities*. London: Jessica Kingsley.
- Marmot, M., & Wilkinson, R. (2000). *Social determinants of health*. Oxford, UK: Oxford University Press.
- Mazankowski, D. (2001). *A framework for reform: Report of the Premier's Advisory Council on Health*. Edmonton: Government of Alberta.
- McBride, S., & Shields, J. (1997). *Dismantling a nation: The transition to corporate rule in Canada*. Halifax, Canada: Fernwood Publishing.
- O'Loughlin, J. L., Paradis, G., Gray-Donald, K., & Renaud, L. (1999). The impact of a community-based heart disease prevention program in a low income, inner city neighbourhood. *American Journal of Public Health*, 89(12), 1819-1826.

- Raphael, D. (2001). Inequality is bad for our hearts: low income found to be a major causes of heart disease in Canada. *CCPA Monitor*.
- Raphael, D. (in press-a). A society in decline: the social, economic, and political determinants of health inequalities in the USA. In R. Hofrichter (Ed.), *Health and social justice: A reader on politics, ideology, and inequity in the distribution of disease*: Jossey Bass/Wiley.
- Raphael, D. (in press-b). Towards the future: Policy and community actions to promote population health. In R. Hofrichter (Ed.), *Health and social justice: A reader on politics, ideology, and inequity in the distribution of disease*. San Francisco: Jossey Bass.
- Raphael, D., & Curry-Stevens, A. (2003). *Toronto charter for a healthy Canada*. School of Health Policy and Management, York University and Centre for Social Justice. Retrieved March 1, 2003, from the World Wide Web: http://www.yorku.ca/ychs/data1/body_publications.html
- Romanow, R. J. (2002). *Building on values: The future of health care in Canada*. Saskatoon: Commission on the Future of Health Care in Canada.
- Shaw, M., Dorling, D., & Davey Smith, G. (1999). Poverty, social exclusion, and minorities. In R. G. Wilkinson (Ed.), *Social Determinants of Health*. Oxford, UK: Oxford University Press.
- Social Exclusion Unit. (2001). *Preventing Social Exclusion*. London: Social Exclusion Unit.
- Taubes, G. (2001). The soft science of dietary fat. *Science*, 291, 2536-2545.
- Teeple, G. (2000). *Globalization and the decline of social reform*. Aurora, Ontario: Garamond Press.
- Wilkinson, R., & Marmot, M. (1999). *Social determinants of health: The solid facts*. World Health Organization (WHO), Europe Office. Retrieved March 1, 2003, from the World Wide Web: <http://www.who.dk/document/E59555.pdf>.
- World Health Organization. (1986). *Ottawa charter for health promotion*. World Health Organization (WHO), Europe Office. Retrieved March 1, 2003, from the World Wide Web: <http://www.who.dk/policy/ottawa.htm>
- Zweig, M. (2000). *The working class majority: America's best kept secret*. Ithaca: Cornell University Press.