Maintaining population health in a period of welfare state decline: political economy as the missing dimension in health promotion theory and practice

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Abstract: There is increasing recognition in the health promotion and population health fields that the primary determinants of health lay outside the health care and behavioural risk arenas. Many of these factors involve public policy decisions made by governments that influence the distribution of income, degree of social security, and quality and availability of education, food, and housing, among others. These non-medical and non-lifestyle factors have come to be known as the social determinants of health. In many nations – and this is especially the case in North America – recent policy decisions are undermining these social determinants of health. A political economy analysis of the forces supporting as well as threatening the welfare state is offered as a means of both understanding these policy decisions and advancing the health promotion and population health agendas. The building blocks of social democracies – the political systems that seem most amenable to securing the social determinants of health – are identified as key to promoting health. Health promoters and population health researchers need to "get political" and recognize the importance of political and social action in support of health. (Promotion & Education, 2006, XIII (4): pp 236-242)

Key words: social determinants of health, health promotion, political economy perspective

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There is increasing recognition in the health promotion and population health fields that the primary determinants of health lay outside the health care and behavioural risk arenas. Decisions made by governments in sectors such as income distribution, social security, education, and housing – summed up in the phrase social determinants of health – are prime contributors to the realization of health. These decisions – which in their entirety may be considered as reflecting commitments to the welfare state – are heavily influenced by politics. Yet, there has been a neglect of the politics of health:

It is profoundly paradoxical that, in a period when the importance of public policy as a determinant of health is routinely acknowledged, there remains a continuing absence of mainstream debate about the ways in which the politics, power and ideology, which underpin it influences people's health (Bambra, Fox, & Scott-Samuel, 2005)

In Canada, there is little explicit acknowledgment by health promoters and population health researchers of the importance of the politics of health. We analyse the role played by politics in determining health by considering the forces behind recent public policy decisions that impact upon the social determinants of health. We focus on Canada – long perceived as a leader in health promotion – to illustrate how political forces that influence the size and quality of the welfare state need to be incorpo-rated into ongoing analyses and practice by health promoters and population health researchers there and elsewhere.

We first describe the social determinants of health and their relationship with public policy. We then provide a description of how policy decisions in these sectors undermine various social determinants of health in Canada. We apply concepts from the field of political economy to show how analysis of the supports for, and threats to, the welfare state offers a way forward for health promoters and population health researchers to gain insights into means of researching and influencing public policy in support of health. We show that the building blocks of social democracies – the political and economic systems that seem most amenable to securing the social determinants of health – appear essential to promoting population health. We identify what these blocks are, show how they result from strong social movements, and provide means of nurturing these social movements in Canada and elsewhere.

KEY POINTS
• The primary determinants of health are the living conditions to which people are exposed.
• The quality of these living conditions are shaped by political and economic forces.
• The decline of support for the welfare state threatens these social determinants of health.
• Political action is required to strengthen the determinants of population health and to reduce health inequalities.

Reviewing health promotion and population health

Health promotion as outlined by the World Health Organization represents a commitment to improve health and well-being through societal change (MacDonald & Davies, 1998). Health promotion has its origins in structural analyses of health issues derived primarily from the social sciences: Health promotion is the process of enabling people (and communities) to increase control over (the determinants of health), and to improve, their health (World Health Organization, 1986).

The words in parentheses were proposed as part of the Charter but not included in the 1986 formulation. In line with its predominantly structural approach to promoting health, the Charter outlined the basic prerequisites for health – or social determinants of health in modern usage – of peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity. One of the five pillars of health promotion action is building healthy public policy.

Each international health promotion conference to the present has reaffirmed the importance of the social determinants of health and public policy that supports these social determinants (ACT Health Promotion, 2004).

Population health concepts focus upon the role societal factors play in determining the health of populations (Evans, Barer, & Marmor, 1994). We would expect it to include analyses of how political, economic, and social forces shape the availability and
distribution of a range of health supporting resources – income, housing, social and health services, etc. – among societal members. Such analyses would provide a context for understanding the quality of various social determinants of health. In reality, most population health approaches place little emphasis upon political and economic forces in favour of more immediate situational issues such as social and physical environments (Raphael, 2004a).

There are therefore, two problems with the state of health promotion and population health research and action in Canada. The first is a continuing emphasis upon individualized approaches to illness prevention related to an ongoing neglect of structural concepts of health promotion and population health by governments, public health and health care workers, and the media (Raphael, 2003a). This emphasis in Canada and the US is well documented (Raphael, 2006a). The second problem – and the focus of this article – is that even among health promoters and population health researchers that take a structural view towards these issues, there is a neglect of the political in the analysis of public policy decisions that influence health.

To illustrate, it is one thing to say that insecure employment is a social determinant of health. It is another to analyze how societal labour policy and density of unionization influence the prevalence of insecure employment (Jackson, 2004; Tremblay, 2004). The former is an apolitical approach, the latter less so. The same questions can be asked about social determinants of health such as income and income distribution, support for early childhood development, and providing housing for all (Langille, 2004). The most developed Canadian approach to population health – the Canadian Institute for Advanced Research formulation – is an example of an apolitical approach to population health determinants (Coburn et al., 2003; Labonte, 1997; Poland, Coburn, Robertson, & Eakin, 1998). UK population health research is notably more policy-oriented – see the Inquiry into Health Inequalities Report (Acheson, 1998) and the Evidence Presented to the Inquiry (Gordon, Shaw, Dorling, & Davey Smith, 1999) – but even this work is seen as neglecting political and economic forces driving policy approaches (Bambra et al., 2005).

### The social determinants of health and public policy

Around the world, governments, health care authorities, and public health officials profess a commitment to promoting the health of citizens. This is especially the case in Canada where health promotion and population health are seen as primary means of assuring the sustainability of the universal public health care system (Kirby, 2002; Romanow, 2002).

The term social determinants of health grew out the search by researchers to identify the specific exposures by which members of different socio-economic groups come to experience varying degrees of health and illness. 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 (Townsend, Davidson, & Whitehead, 1992). Table 1 provides recent formulations of the social determinants of health. Overviews of the concept, recent findings, and an analysis of emerging issues are available (Marmot & Wilkinson, 2006; Raphael, 2004b; Raphael, 2006b). All these formulations share a concern with factors beyond those of biomedical and behavioural risk. The SDOH National Conference list is unique in that it specifically focuses on the public policy environment (e.g., income and its distribution) rather than characteristics associated with individuals (e.g. income and social status) (Raphael, 2004a).

Recent work summarizes the status of these social determinants of health in Canada and the US and the pathways by which these come to influence North Americans’ health (Raphael, 2003b; Raphael, 2004b). Most analyses conclude that the quality of many social determinants of health are threatened (Raphael, Bryant, & Curry-Stevens, 2004). And these threats result from policy decisions being made by governments at local, provincial/state, and federal levels.

Public policy is important for health promotion and population health because it determines the quality of the social determinants of health. In Canada and elsewhere, there is increasing recognition of the social determinants of health and how the formulation and implementation of public policy influences the quality of these determinants (ACT Health Promotion, 2004). In Canada, Health Canada and Canadian Public Health Association statements and documents argue the best means of promoting health and maintaining the sustainability of the public health care system is through healthy public policy that strengthens the societal determinants of health (Canadian Public Health Association, 2001; Health Canada, 1999). The establishment of the World Health Organization’s Commission on the Social Determinants of Health underscores this emerging recognition (World Health Organization, 2004).

### Canadian public policy and the social determinants of health

What is the nature of policy change in Canada that threatens the quality of numerous social determinants of health? The most obvious manifestation of the public policy environment is government program

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spending as a percentage of Gross Domestic Product (GDP). In 1992 the proportion of Canadian GDP allocated to program spending began to decline such that spending levels are now at late 1940’s levels (Hulchanski, 2002). Canadian governmental program spending as a proportion of GDP is now among the lowest of developed nations (Bryant, 2006).

Government spending is a key aspect of how societies differ in their commitment to social infrastructure and support for citizens across the life-span (Shaw, Dorling, Gordon & Davey Smith, 1999). Such differences in spending – correlated strongly with a range of other ideological commitments – provide a context for understanding the environments in which health promotion and population health activities are situated (Navarro & Shi, 2001). The states of three key social determinants of health illustrate current policy environments in Canada: income and its distribution, housing, and early childhood development.

Income and income distribution

2001 Canadian census data show a disturbing picture of incidence of low income [similar to what is internationally termed the poverty rate] among Canadians (16.2% of individuals and 12.6% of families) (Statistics Canada, 2004b). The low income rate for female-led single families is 56%. The incidence of low income is especially high among residents of major Canadian urban areas where over 20% of Vancouver families are so identified, 19% of Toronto families, and 23% of Montreal families. Thirty percent of children aged 17 years and under live in conditions of low income in Vancouver and Toronto and 34% in Montreal, an issue with profound importance for healthy child development. As pointed out in numerous national and international reports, these figures are very high in international comparison (Canadian Population Health Initiative, 2004).

Much of this has to do with the failure of income transfer programs to distribute income and wealth more equitably across the population as is the case in many other developed nations. Two volumes provide very recent analyses of where Canada stands in relation to other industrialized nations (Innocenti Research Centre, 2005; Rainwater & Smeeding, 2003).

Housing

Housing is an important social determinant of health. Spending excessive amounts of income on housing reduces resources available for other social determinants of health such as food and recreation (Bryant, 2004a). The proportion of tenants spending >30% of total income on rent is very high in Canadian cities (43% in Vancouver, 42% in Toronto, and 36% in Montreal (Statistics Canada, 2004a)). The proportion spending >50% — putting them at risk of imminent homelessness is also strikingly high (22% in Vancouver, 20% in Toronto, and 18% in Montreal). A significant proportion of urban dwellers (>8%) live in substandard housing. A recent report documents how rental costs have far outpaced income increases among low-income renters in virtually all Canadian urban areas (for Vancouver the discrepancy is 45%, Toronto 62%, Montreal data is not available (Federation of Canadian Municipalities, 2004).

Healthy child development

Healthy childhood development is a major social determinant of health. Positive conditions during childhood not only support child health, but have long lasting effects on health and the development of disease during adulthood (Friendly, 2004). Healthy childhood development is influenced by other determinants of health such as adequate income, housing and food security. Regulated quality childcare is particularly important in early child development. It has an especially positive impact on children living in the worst socio-economic conditions. Outside of Quebec, the availability of regulated childcare for Canadian families is 10%-15% (Friendly, 2004). Recent analyses document how the amount of money allocated to regulated childcare in each of the provinces of interest trails well behind allocations made in Quebec (Campaign 2000, 2003).

How can we understand the forces that influence these public policy decisions? Sadly, the health promotion and population health literatures offer relatively little to answer these questions (Bambré et al., 2005; Coburn, 2000, 2004, 2006; Lynch, 2000; Muntaner, 1999; Navarro, 2004). The political economy literature helps us fill this gap.

The politics of public policy: insights from political economy

Political economy is about the relationships among the state, economy, and civil society (Hofrichter, 2003). As an area of inquiry, it provides insights that link specific disciplines such as political science, economics, and sociology (Armstrong, Armstrong, & Coburn, 2001). The issues considered within such a perspective are the production and distribution of wealth, the relative political power of social classes that is related to issues of capital accumulation and the organization of labour, and the extent to which society relies extensively on state control of the distribution of resources versus market control of such activities (Esping-Andersen, 1985, 1990, 1999, 2002).

Critical health researchers use these concepts to argue that how a society produces and distributes societal resources among its population — that is, its political economy — are important determinants of population health (Coburn, 2000, 2004, 2006; Navarro, 2002; Navarro & Muntaner, 2004). These links become clearer as evidence accumulates of how income distribution, employment conditions, and availability of social and health services are important determinants of population health (Marmot & Wilkinson, 2006; Raphael, 2004b).

In the following sections we identify some of this work and outline political economy concepts that should be considered by health promoters and population health researchers. The following has particular relevance for developed nations, but these concepts are relevant for developing nations as well. The key concepts are the welfare state, differences among welfare states, and the forces that either support or threaten the quality of the welfare state.

Defining the welfare state

The idea of the modern welfare state encapsulates many political economy concepts. Canadian political economist Gary Teeple defines the welfare state as:

... a capitalist society in which the state has intervened in the form of social policies, programs, standards, and regulations in order to mitigate class conflict and to provide for, answer, or accommodate certain social needs for which the capitalist mode of production in itself has no solution or makes no provision” (Teeple, 2000, p.15).

In Globalization and the Decline of Social Reform, Teeple links decaying policy environments to increasing economic globalization (Teeple, 2000). He sees increasing income and wealth inequalities and the weakening of social infrastructure within Canada and elsewhere as resulting from the ascendance of concentrated monopoly capitalism associated with corporate globalization. Transnational corporations—many with home bases in the USA—actively apply their increasing power to oppose reforms associated with the welfare state to reduce labour costs. Teeple’s analysis of the effects of economic globalization is consistent with other work on the evolution of the Canadian welfare state (Banting, Hobeg, & Simeon, 1997), the US situation (Hofrichter, 2003; Zweig, 2000) and UK developments (Farnsworth, 2004; Lexy, 2001).

For Teeple, the forces that led to the development of the welfare state at the end
of World War II were strong national identities, the need to rebuild Western economies, the strength of labour unions within national boundaries, the perceived threat to business of socialist political alternatives, and a consensus for political compromise to avoid the boom-bust cycles of the economy. These led to policies that supported a more equitable distribution of income and wealth through social, economic, and political reforms. However, the effects of economic globalization are not identical across nations, and some of the changes in public policy among these types. The social democratic welfare states (Finland, Sweden, Denmark, and Norway) emphasize universal welfare rights and provide generous benefits and entitlements. The Conservative welfare states (France, Germany, Spain, and Italy) also offer generous benefits but based on employment status with emphasis on male primary bread-winners. The liberal Anglo-Saxon economies (UK, USA, Canada, and Ireland) provide only modest benefits and step in only when the market fails to provide adequate supports. These liberal states depend on means-tested benefits targeted to only the least well-off. It is usually assumed that Canada public policy is very different from the USA, but it is closer to the USA in its welfare provisions that to Social democratic (SD) nations and Conservative (CN) nations (Bernard & Saint-Arnaud, 2004).

These concepts are very useful for understanding why nations differ systematically in their commitment to strengthening the social determinants of health. Tremblay applies the typology to understand current employment policy in Canada (Tremblay, 2004) while Friendly does so in relation to Canadian approaches to early childhood education care (Friendly, 2004). Jackson considers how the typology helps explain the state of employment and working conditions in Canada (Jackson, 2004).

These differences among nations help explain variations in population health. Navarro and Shi report that in nations predominantly governed from 1945-1980 by social democratic political parties show greater union density, social security expenditures, and employment levels (Navarro & Shi, 2001). They had the largest public expenditure in health care from 1960-1990, and greatest coverage of citizens by health care. These nations had high rates of female employment, and lowest income inequalities and poverty rates. On a key indicator of population health — infant mortality — they had the lowest rates from 1960-1996. Recent work extends these findings to life expectancy with similar advantages associated with SD nations (Navarro et al., 2004).

These findings suggest that health promoters concerned with the social determinants of health and public policies that strengthen them need to look to the nations ruled by social democratic parties for insights and ideas for promoting health. What are the political and economic forces that lead to such approaches to health and well-being?

The building blocks of health public policy and population health

The Canadian public policy situation in relation to the social determinants of health compares poorly to many other developed nations and especially to the social democratic nations of Denmark, Norway, Sweden, and Finland (Navarro & Shi, 2001). What are the building blocks that make the social democratic nations receptive to such an agenda? Based on an extensive review of the political economy literature, Bryant identifies the following political and economic forces that support health-enhancing public policies (Bryant, 2006):

• The ability of “left” parties to influence government decision-making (Brady, 2003; Navarro et al., 2004; Rainwater & Smeeding, 2003).
• This ability is strengthened by adoption of proportional representation in the electoral process (Alesina & Glaeser, 2004; Esping-Andersen, 1985).
• High union density and the ability of unions to provide a united front in negotiating wages and employment conditions (Alesina & Glaeser, 2004; Navarro et al., 2004).
• Proactive governmental action in developing a range of public policies. These involve commitments to active labour policy (training, supports, and unemployment benefits), support for women’s employment, adequate spending to support families, providing assistance to the unemployed and those with disabilities, and providing educational and recreational opportunities (Esping-Andersen, 1990, 1999, 2002).
• Commitment to policies that reduce social exclusion and promote democratic participation (Navarro et al., 2004).

Navarro and colleagues provide compelling evidence that these policies positively influence health in industrialized nations (Navarro et al., 2004). These policies can be explicitly conceived as health promotion and population health activities and goals. For one outstanding example, see the documents associated with the Swedish National Public Health Policy (Swedish Ministry of Health and Social Affairs, 2001, 2003; Swedish National Institute for Public Health, 2003). The actual Swedish National Public Health goals are summarized in Table 2.
The Swedish Government has defined 11 target areas for work in the field of public health:

- Involvement in and influence on society
- Economic and social security
- Secure and healthy conditions for growing up
- Better health in working life
- Healthy, safe environments and products
- Health and medical care that more actively promotes good health
- Effective prevention of the spread of infections
- Secure and safe sexuality and good reproductive health
- Increased physical activity
- Good eating habits and safe foodstuffs
- Reduced use of tobacco and alcohol, a drug and doping-free society and a reduction in the harmful effects of excessive gambling.


Conclusion: implications for health promotion and population health

Recent scholarship is placing differences in the quality of social determinants of health—and resultant population health—within these explicitly political perspectives (Coburn, 2000, 2004, 2006; Navarro, 2002; Navarro & Muntaner, 2004). Raphael and Bryant have compared the determinants of women’s health in Canada with that seen in the UK, USA, Sweden and Denmark (Raphael & Bryant, 2004). Jackson (2002) has compared Canada with the USA and Sweden. These differences in national indicators have clear ideological and political antecedents (Navarro & Shi, 2001).

Health promotion—and population health—theory and research identifies the processes by which societal determinants influence health and means by which these determinants can be influenced by citizens. However, political and economic forces shape the quality of these societal determinants and state receptivity to these ideas (Bryant, 2002; Bryant, 2004b, 2006). And it is clear there are political dimensions that underlie the conditions that support population health.

While Canada is a liberal welfare state, members of the liberal welfare state club are not monolithic in policy approaches. Canada developed a universal healthcare system while the USA did not. The UK embarked upon a systematic policy initiative to reduce child poverty while Canada has not. Nations systematically shift their basket of public policies to become outliers within their welfare state group. This suggests room for policy action in support of health.

There are two issues to be faced by health promoters and population health researchers in Canada and elsewhere. The first is to confront the continued dominance of lifestyle and behavioural approaches to health promotion among practitioners and the understandings held by the media and public concerning the sources of health and illness. The second problem is to move those who are looking at broader issues such as the social determinants of health to take an explicitly political approach to understanding health determinants as means of moving the health agenda along.

Such a political approach would recognize that the social democratic nations create the conditions necessary for health. These conditions include equitable distribution of wealth and progressive tax policies that create a large middle class, strong programs that support children, families, and women, and economics that support full employment: For those wishing to optimize the health of populations by reducing social and income inequalities, it seems advisable to support political forces such as the labor movement and social democratic parties which have traditionally supported larger, more distributive policies (Navarro & Shi, 2001).

And while it is clear that Canadian public policy has been moving more and more towards a neo-liberal US-type model, reversals are possible. Indeed, the UK reversed twenty years of harsh conservative rule through election in 1997 of a Labour government that is addressing health inequalities. Similarly, New Zealand took a similar neo-liberal course during the 1990s, but then reversed direction. Ideologies are malleable and national social policies can be changed. There are various means by which these shifts can be assisted (Raphael & Curry-Stevens, 2004). Two primary arenas for action—among others—for health promoters and population health researchers are advocacy and community-based action. Each is considered briefly in turn.

Advocacy

Advocacy is about influencing governments to enact policies in support of health. This requires that health promoters and population health researchers be more explicit concerning their analysis of the role governments play in influencing the social determinants of health. It also requires explicit recognition of the role political and economic forces play in shaping these policies and the need to confront these sources of power and influence when they threaten health and well-being. Once these forces are acknowledged, health promoters and population health researchers must go public with these conclusions to influence public policy (Raphael & Bryant, 2006). Numerous Canadian advocacy organizations working on poverty alleviation, social justice, and fair social assistance rates and wages already draw upon these findings in support of their efforts (Campaign 2000, 2004; Curry-Stevens, 2003; National Council of Welfare, 2004). Closer alliances with these organizations need to be forged.

Community-based education and research

At the community level citizens can be involved in these activities through a process of participatory policy research. In this approach citizens are asked to consider decisions that governments and agencies make that are influencing their health and well-being. It is similar to conventional participatory research with the exception that the focus of community members is clearly directed towards public policy rather than local community issues. Again, the main task is to highlight the role that political and economic forces play in shaping the social determinants of health and help support community action in defense of healthy public policy (Bryant, Raphael, & Travers, in press). Collaborative efforts between health promoters and population health researchers and citizens have taken place (Bryant et al., 2001; PATH Project, 1997; Raphael et al., 2001). More needs to be done.

The best means therefore of promoting health and improving population health involves Canadians—and others—being informed about the political and economic forces that shape the health of a society. Once so empowered, they can consider political and other means of influencing these forces. Health promoters and population health researchers need to “get political” and recognize the importance of political and social action in support of health. This seems a rather daunting task, but one that holds the best hope of promoting the health of citizens in Canada and elsewhere (Bryant, Raphael & Rioux, 2006).