HOW TO THINK ABOUT SOCIAL DETERMINANTS OF
HEALTH: REVITALIZING THE AGENDA IN CANADA

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Abstract

Five years after the release of the report of the WHO Commission on Social Determinants of Health, limited progress has been made in advancing its agenda of reducing health inequity by way of action on the social determinants of health, despite the added urgency introduced by the post-2008 financial crisis. With a focus on Canada but drawing on developments and issues elsewhere, we identify three directions for revitalizing the agenda: challenging “lifestyle drift”; thinking differently about questions of how much evidence is enough to justify action (the standard of proof); and focusing on policy priorities, with the recognition that public finance is a public health issue. We conclude with observations about the need to break down the “silos” that impede governmental action on social determinants of health, and to build public support for such action more effectively than has been the case to date.
Provenance and Acknowledgments

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“Realism is to put our ambition at the level of our challenges”
José Manuel Barroso (2012), President of the European Commission

Introduction

In August 2008, the World Health Organization’s Commission on Social Determinants of Health (2008) released its final report. The report, a product of three years’ work by 19 Commission members and a large multinational supporting cast of researchers, was organized around the concepts of health equity and socioeconomic gradients in health. Health equity was defined with reference to the absence of systematic differences in health that are avoidable by reasonable action ... and the Commission emphasized that it considered most such differences to be avoidable and therefore inequitable (2007, p. 1). Socioeconomic gradients in health are disparities in health outcomes related to various indicators of social (dis)advantage; such gradients are ubiquitous, not only between countries but also within them. For example, the Code Red study of Hamilton, Ontario – a novel collaboration between university researchers and an investigative journalist in a metropolitan area whose economy had been devastated by the loss of manufacturing jobs - found a difference of 21 years in average age of death between one of the wealthiest neighbourhoods and one of the poorest (Buist, 2010). The Commission further emphasized (2008, p. 1) that the “unequal distribution of health-damaging experiences is not in any sense a ‘natural’ phenomenon but is the result of a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics”

As a financial crisis swept across the world two months after the release of its report, acting on the Commission’s focus on improving daily living conditions and tackling “the inequitable distribution of power, money, and resources – the structural drivers of those conditions of daily life” (the Commission’s words) on multiple scales should have emerged as imperative. Worldwide, an estimated 35 million people were rapidly thrown out of work by the crisis (Calvo, 2010). In the United States, by mid-2013 more than 47 million people were receiving the federal food vouchers known as food stamps, and
millions more were eligible (Food Research and Action Center, 2013). In the United Kingdom, where one of us now lives and works, deficit reduction is being pursued through major cuts to existing social protection programs, against a background of a health gap between rich and poor that was, on many measures, already wider than at any point since the Great Depression (Thomas, Dorling, & Smith, 2010; Yeates, Haux, Jawad, & Kilkey, eds. 2011; Taylor-Gooby, 2012; Taylor, Burn-Murdoch, & Butler, 2013). In low- and middle-income countries (LMICs), the initial response to the crisis in terms of social protection was described as “minimal” (McCord, 2010) and by 2010 public sector austerity programs in many countries threatened to worsen the effects of multiple crises (in food and fuel prices as well as finance) rather than ameliorating them (Ortiz, Chai, & Cummins, 2011). Yet in contrast to the rhetoric of some official documents (see e.g. Strategic Review, 2010; World Health Organization Regional Office for Europe, 2012), high-level political recognition of the potential health consequences of the crisis and many policy responses to it has been minimal or nonexistent, despite the accumulating evidence that austerity programs are not only economically counterproductive but also present short- and long-term threats to health equity (McKee, Karanikolos, Belcher, & Stuckler, 2012; Karanikolos et al., 2013).

**Box 1: Recognizing the importance of social determinants of health**

“No matter how sophisticated our population health interventions, they won’t adequately address inequities if we exclusively focus on proximal determinants and tinker at the edges of structural disadvantage” (Nancy Edwards, Scientific Director, Canadian Institutes of Health Research Institute of Population and Public Health, 2011)

“Achieving health equity will depend in large part on decisions made outside of the health care system, to address core social determinants of health, including income inequality and poverty, educational barriers and underemployment, unsafe working and living conditions, and systemic discrimination and racism” (Murphy et al., 2012)
Canada should have been well placed to take forward the agenda articulated by the Commission, and to address the financial crisis in ways that incorporated concern for health equity and social determinants of health. Canadian researchers highlighted the importance of social determinants of health well before the term was in widespread use (Evans & Stoddart, 1990), and in 2009 a Senate committee issued related reports on population health and social policy that stated the case for a social determinants of health approach and, more generally, for concerted efforts to eliminate poverty (Subcommittee on Population Health, 2009; Subcommittee on Cities, 2009). Yet even before the crisis, it was fair to characterize Canada as “a land of missed opportunity” in this respect (Bryant, Raphael, Schrecker, & Labonté, 2011), and after the crisis policy attention to social determinants of health, which had never been robust, almost disappeared. Leading researchers continue to say the right thing (see Box 1), but their insights are not incorporated into public policy or research priorities.

An obvious rejoinder is that, in Canada as elsewhere, concerns with public sector deficits associated with falling revenues and the need for stimulus programs that avoided an even more serious recession have simply eclipsed ‘soft’ concerns like health equity. This is true as description, but of limited value as explanation. Rather, it is important to ask why such concerns have predominated, and how substantively to revive an agenda for research and policy that places health equity and social determinants of health at the forefront, recognizing – as did the recent review of health disparities in the World Health Organization’s European region (Marmot, Allen, Bell, Bloomer, & Goldblatt, 2012) – their special importance in the current economic context and in an uncertain economic future. This latter question is our primary concern, and we address it in the three sections of the paper that follow, which describe three essential ways of thinking differently about health policy, in the broadest sense. A concluding section, necessarily more tentative, explores directions for action in the context of the hard politics of austerity and rising inequality, in Canada and across the world.
Thinking differently: Challenging “lifestyle drift”

Popay, Whitehead, & Hunter (2010) describe lifestyle drift as “the tendency for policy to start off recognizing the need for action on upstream social determinants of health inequalities only to drift downstream to focus largely on individual lifestyle factors.” Lifestyle drift is endemic in Canadian health promotion and public health (Dupéré et al., 2007, p. 373; Frohlich & Poland, 2007, p. 47; Low & Thériault, 2008). For example, a survey of initiatives related to healthy eating and physical activity in Ontario and British Columbia (Gore & Kothari, 2012) found a preponderance of lifestyle- or environment-based rather than structure-based initiatives, even using a broad and inclusive definition of the latter category. However, the unaffordability of a healthy diet for low-income Canadians has repeatedly been demonstrated ([Toronto] Medical Officer of Health, 2010; Ottawa Public Health, 2011; Williams et al., 2012; Dietitians of Canada, 2012) – the tendency is for such a diet to become less affordable over time – as has the extent of food insecurity (Tarasuk & Beaton, 1999; Dubois, 2005; Tarasuk & Vogt, 2009). In Ontario, more than 400,000 people relied on food banks at least once during March, 2012, the month of the most recent survey (Food Banks Canada, 2013). Inability to afford a healthy diet has special implications for the health of people trying to manage conditions like Type 2 diabetes (Dinca-Panaitescu et al., 2011). As Marmot and colleagues have noted: “It is hard to see how even ideologically driven commentators could think that having insufficient money to live on is irrelevant to health inequalities” (Marmot, Allen, & Goldblatt, 2010, p. 1256).

Beyond the simple arithmetic of (un)affordability, structural influences include metropolitan food deserts: areas that lack stores selling healthy foods, in particular full-service grocery stores, but abound in convenience stores and fast food outlets (Beaulac, Kristjansson, & Cummins, 2009; Treuhaft & Karpyn, 2010). In one such neighbourhood in downtown Halifax, a wheelchair-bound resident spends $20 on taxis every time he goes to the nearest supermarket; the taxis are a necessity because purchases in his wheelchair basket may otherwise be stolen (Beaumont, 2012). Quite apart from how much time is consumed by the daily logistics of living on a limited income (cf. Matthews, Detwiler, & Burton, 2005), some (mainly low-income) neighbourhoods come with the risk of being run
down in a crosswalk or caught in a crossfire, seriously limiting their activity-friendliness. The Institute of Medicine states the generic point in the US context: “The causes of the obesity epidemic are multifactorial, having much more to do with the absence of sidewalks and the limited availability of healthy and affordable foods than a lack of personal responsibility” (Institute of Medicine, 2012, summarizing Glickman, Parker, Sim, Cook, & Miller, eds., 2012). This is far from a comprehensive overview of the connections between economic inequality (including spatial segregation) and diet and nutrition, but it suffices to demonstrate the limited relevance if not the perniciousness, from a health equity perspective, of health policies that neglect structural influences and systemic disadvantage.

Nevertheless, a preoccupation with lifestyle rather than structural influences is evident in health promotion materials such as a brochure produced by two high-profile Canadian non-profits that advises people with high scores on a stress checklist to: “Stop. Re-think. Change your lifestyle. Improve your diet. Make physical activity a regular routine, and above all, try to find ways to relax. Is it running? Knitting? Spending time with your kids? Try to positively alter your attitudes” and seek credit counseling if financial worries are a major source of stress (Heart & Stroke Foundation & Canadian Mental Health Association, 2009). Every question in the checklist asks about how the affected individuals respond to stress; none considers sources of stress in the social context environment, or the underlying macro-scale economic and social processes. The approach taken in this brochure exemplifies an especially pernicious dimension of lifestyle drift: its manifestations may reinforce attributions of responsibility for health to individuals and their ‘choices,’ diverting attention from a social context that offers a far broader range of choices to some individuals than to others – what the Commission on Social Determinants of Health called “the inequitable distribution of power, money, and resources,” which was the topic of one of its three overarching recommendations. We return to this theme in the concluding section of the paper. Meanwhile, we wonder about the relevance of “run, knit and relax” nostrums for people like the former employees of the Electro-Motive Diesel plant in London, Ontario (Box 2).
Box 2: Economic restructuring and job destruction

Employees at Electro-Motive Diesel in London, Ontario were told by the parent company in January, 2012 to choose between taking a 50 percent pay cut or having their work relocated to a lower-wage jurisdiction (Grant, 2012a). The company made good on its threat and closed the plant, which as of late 2012 stood vacant, as shown above. Several months later, just 68 of the 485 production workers had found new full-time jobs, marriages were crumbling, and food bank use was climbing (Grant, 2012b).

This is a local, small-scale illustration that stressful conditions of life and work are rooted in economic and social processes that are outside individuals’ control (see also Marmot, 2004, p. 109-141). The experience of Electro-Motive’s workers conforms to a pattern that occurred throughout the high-income world starting as early as the 1970s, albeit with considerable national variation, as manufacturing operations shifted to lower-cost jurisdictions, often in developing countries but sometimes closer to home (see e.g. Gringeri, 1994). The effects of this deindustrialization have received too little attention from population health researchers.
Thinking differently:
How much evidence is enough? What kind of evidence? Who decides?

Given the popularity of ‘evidence-based’ medicine and health policy, critical perspectives on these questions are especially important. Health researchers and those making use of their findings often operate on the basis of a hierarchy of evidence with randomized controlled trials (RCTs), ideally repeated to test transferability, and large-scale prospective epidemiological studies at the top. In many respects, this is an inappropriate approach to understanding social determinants of health and interventions to address them – leading inexorably (and inaccurately) to the conclusion that almost nothing works.

It is useful to revisit a 1978 article critiquing the standard of proof often adopted in assessing scientific evidence concerning “environmental risks” like toxic chemical exposures, which share such characteristics as incomplete knowledge of the mechanism of action, long latency periods between exposure and illness, and irreversibility. Author Talbot Page emphasized that: “In its extreme, the approach of limiting false positives,” i.e. Type I errors or incorrect rejections of the null hypothesis, “requires positive evidence of ‘dead bodies’ before acting” (Page, 1978, p. 237). This is not rhetoric, but rather a precise and literal characterization of the demand for ‘positive’ epidemiological findings of increased mortality either as a requisite for inferring causation or as a threshold for regulation or other policy action. Page went on to argue that minimizing Type I errors may be a thoroughly inappropriate basis for incorporating scientific evidence into public policy, because it fails to take into account the relative consequences of minimizing Type I and Type II errors (false negatives). Since uncertainty is pervasive with respect to the effects of environmental risks, Page argued that attention to these comparative consequences in regulating such risks is imperative. Critically, waiting for more or better evidence does not resolve the problem, because as environmental epidemiologist Philippe Grandjean has pointed out, “deferring a decision is a decision in itself” (Grandjean, 2004; cf. Jellinek, 1981).

The question of how much evidence is enough to justify acting on social determinants of health must be addressed with explicit reference to the values at stake. Even in high-income jurisdictions with extensive health data, mortality measures may be
insufficiently sensitive to capture deteriorations in health status except in the case of catastrophic disruptions like the collapse of the former Soviet economy (Frank & Haw, 2011). For how long is it justifiable to defer action while waiting for health outcome data that may, given the accumulation of effects of disadvantage over the life course, be decades in coming – the effect that has been described as “epidemiological inertia” (Frank & Haw, 2011)? Instead, should evidence of causal relations with such risk factors as overweight or allostatic load be sufficient to justify policy change? Even this strategy may not cast the net widely enough. As noted in a recent literature review, “many strategies aimed at obesity prevention may not be expected to have a direct impact on BMI, but rather on pathways that will alter the context in which eating, physical activity and weight control occur. Any restriction on the concept of a successful outcome, to either weight-maintenance or BMI measures alone, is therefore likely to overlook many possible intervention measures that could contribute to obesity prevention” (Mooney, Haw, & Frank, 2011, p. 22). No simple algorithm will answer these and similar questions, which should be addressed directly as matters of public health ethics, but it is worth noting Marmot’s view that “the best should not be the enemy of the good. While we should not formulate policies in the absence of evidence to support them, we must not be paralysed into inaction while we wait for the evidence to be absolutely unimpeachable” (Marmot, 2000, p. 308). This insight has important implications not only for public policy, but also for how health professionals are trained to evaluate bodies of research evidence – an issue that deserves further exploration.

The use of the RCT as the gold standard for intervention research must similarly be reconsidered. As noted in a recent US study of that country’s relatively poor overall health status, many kinds of interventions and policies cannot be assessed using RCTs, for reasons of ethics, logistics, or both. Thus, insistence on RCTs builds into intervention research a bias against larger-scale, contextual interventions that are difficult if not impossible to evaluate in this manner (National Research Council & Institute of Medicine, 2013, p. 164, 262-263; see also Schrecker, Acosta, Somerville, & Bursztajn, 2001, p. 1679-1682). This bias may contribute to lifestyle drift, since interventions that focus on changes in individual behaviour are more amenable to RCT study designs as well as being easier to manage and
less demanding in terms of their resource requirements. Marmot (2000, p. 308) has noted that: “The further upstream we go in our search for causes, the less applicable is the randomized controlled trial. … We must therefore rely on observational evidence and judgment in formulating policies to reduce inequalities in health.”

**Box 3: The need for methodological self-consciousness**

Epidemiologists take for granted the test for statistical significance at a 95 percent confidence level – a test designed to minimize Type 1 errors. However, reporting associations that fail to meet this test as “not significant” runs the risk of confusing lack of evidence of an effect with evidence of the lack of an effect – and, more fundamentally, fails to recognize problems of limited statistical power and the fact that “the choice of a value for statistical significance is arbitrary in relation to the statistical significance tests themselves. It depends,” or at least perhaps it should depend, “on a judgment as to how serious the consequences of error will be …” (Broadbent, 2011, p. 11). Such issues are often not adequately considered in reviews of research findings. An example of quite a different kind comes from a recent critique of studies of neighbourhood effects, e.g. on the chance of escaping poverty, that presume that causal pathways run from residential location to life chances rather than in the opposite direction: “If where any given individual lives affects their life chances as deeply as neighbourhood effects proponents believe, it seems crucial to understand why that individual is living there in the first place” (Slater, 2013, p. 369). Like choices about whether to consider impacts on relevant pathways as well as evidence on ultimate health outcomes, this is a fine illustration of the need for explicit attention to what Shrader-Frechette and McCoy (1993, p. 84-101) characterize as methodological value judgments. These methodological value judgments often are not taken into account either in research design or in the evaluation of research findings by knowledge users.

This does not mean ignoring evidence, but does mean recognizing the importance of methodological pluralism, involving what has been called a “portfolio of evidence” (Kim, 2003) that includes both qualitative and quantitative findings. The method of realist review (Pawson, Greenhalgh, Harvey, & Walshe, 2005) approximates this approach at the level of research synthesis, provided that the range of methodologies and disciplines included is sufficiently broad, and that attention is paid to the values that may be embodied
in the design of particular studies (Box 3). Similarly, complex population health problems are best approached by way of a “portfolio of interventions” (Swinburn, Gill, & Kumanyika, 2005) supported by distinctive evidence bases. Obviously, ongoing evaluation of interventions and policy changes is important – and of course until and unless undertaken on a meaningful scale they cannot be evaluated! – but how much more evidence is needed to demonstrate (for instance) the imperative of increasing the incomes of people for whom eating a healthy diet while keeping a roof over their heads is arithmetically impossible? To stay with this example, although perhaps not a sufficient condition for reducing food insecurity, addressing inadequacies of income is surely a necessary condition. Why, then, have governments and health promoters alike neglected questions of the affordability of a healthy diet, and what can be done to overcome that neglect?

Thinking differently: Focusing on priorities

While increasing unemployment and economic hardship, the recent recession has led to large government budget deficits (the result both of reduced revenue and the costs of bailouts and stimulus spending) and the prospect of several years of slow or uncertain economic growth. Against this background, the tendency is to regard policies and interventions like those called for in Box 1 above as ‘unrealistic’ or unaffordable, to be thought about only when times are better. This position repudiates the explicit normative commitment of the Commission on Social Determinants of Health to social justice and redistributing resources in a way that reduces health inequities. We prefer the perspective on realism that introduces this paper, starting from recognition that in the Canadian context, affordability of the relevant policies and interventions is not an issue in any absolute sense. Rather, the issue is one of priorities – of how, and for whose benefit, society’s resources should be allocated. Resource scarcities for investment in social determinants of health are consequences - in the words of Calabresi and Bobbitt’s Tragic

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1 Parts of this discussion are adapted from an earlier article (Schrecker, 2013), but the argument is hardly new. For example former US president Dwight Eisenhower observed in 1953 that: “Every gun that is made, every warship launched, every rocket fired, signifies, in the final sense, a theft from those who hunger and are not fed, those who are cold and are not clothed” (quoted in O’Connell, 2012).
Choices - “of the decision by society that it is not prepared to forgo other goods and benefits in a number sufficient to remove the scarcity” (Calabresi & Bobbitt, 1978, p. 22).

Here is a parochial example. In June 2011, with the Ontario government facing a $14 billion budget deficit, the province nevertheless found more than $200 million to widen a short stretch of freeway on the eastern edge of Ottawa. This announcement was made the day after the Ontario Non-Profit Housing Association (2011) released an annual survey showing that more than 150,000 households were on waiting lists for affordable housing. The $200 million could have been used, instead, as seed money for an expanded program of building affordable housing, or in a variety of other ways that could have made a direct contribution to reducing health disparities by way of acting on social determinants of health. It’s a matter of priorities, and if the social determinants of health agenda is to be revitalized then advocates, including public health professionals, must be willing to trespass on the sacred terrain of public budgets to argue for different priorities. Although the connection between economic inequality per se (rather than specific manifestations or corollaries of inequality) and health outcomes is contested, the case for trespassing is strengthened by evidence that the distribution and objectives of government expenditure have a more powerful role that the structure of taxation in reducing economic inequality and manifestations such as poverty (Campbell, 2012). Internationally, the central role of social protection in reducing health inequities, especially in a time of economic crisis, has been recognized by the WHO European Review (Marmot et al., 2012). Tools like health equity impact assessment (Mahoney, Simpson, Harris, Aldrich, & Williams, 2004; Orenstein & Rondeau, 2009; Ontario Ministry of Health and Long-term Care, 2012) can be valuable, but to realize that value, their use cannot be confined to incremental changes in program spending or to the health care system; they must be applied to the overall expenditure budget, systematically and transparently.

Public finance, in other words, is a public health issue. This includes the revenue as well as the expenditure side of the equation. The connection of the revenue side with health equity is illustrated, perhaps unintentionally, by the Drummond report on Ontario’s financial future, which envisioned no new spending on increasing social assistance rates or affordable housing until after the anticipated balancing of the provincial budget in 2017-
2018 (Commission on the Reform of Ontario’s Public Services, 2012). The Commission had been directed not to consider any form of new taxation – resulting in a set of fiscal projections in which government revenues as a percentage of the province’s economic product actually decline slightly. The report did, however, provide the basis for constructing a scenario based on an alternative revenue assumption in which the provincial treasury’s “own source” revenues – that is, revenues from provincial taxes and fees rather than federal transfers – rise to their 1999-2000 level of 15.9 percent of the province’s economic product. Under this scenario, using the report’s expenditure assumptions the province would be running a $22.6 billion budget surplus in 2017-2018 – or, looking at the issue another way, $22.6 billion would be available for program spending while balancing the budget in that fiscal year (Box 4).

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<th>Box 4. Public finance is a public health issue: The Drummond report and an alternative fiscal scenario</th>
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<td><strong>Actual 2010-11</strong></td>
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<td><strong>Value of provincial GDP, $ billion</strong></td>
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<td><strong>Own-source revenue as % of GDP</strong></td>
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<td><strong>Own-source revenue, $ billion</strong></td>
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* Calculated as reduced from 3.8% of GDP to 3.3 as per report
** Alternative revenue assumption: Expenditures as projected, but Ontario own-source revenue restored to 1999-2000 level of 15.9% of GDP (as per report, p. 114)

What steps could be taken to reduce health inequities if even some of those resources were directed toward social determinants of health? This should not be treated
as a rhetorical question given the recognition by the WHO Euro review of the importance of social protection. Indeed, the Commission for the Review of Social Assistance in Ontario (2012a) recommended an immediate increase of $100 per month (as well as an increase in allowable earnings with no clawback to $200 per month) for “the lowest rate category, single adults receiving Ontario Works, as a down payment on adequacy while the system undergoes transformation” (Commission, 2012b). The 2013 provincial budget took small steps toward that transformation, but at least one commentator concluded that “Ontario’s best hope of creating a modern, humane social assistance system has expired” (Goar, 2013). Whether or not that is the case, the budget did not address the revenue side of the equation, and the generic point that budgetary priorities matter for health equity remains crucial.

Budgetary priorities matter in health research, as well, and strengthening the evidence base for acting on social determinants of health requires new directions and initiatives that are not primarily concerned with health care provision (Östlin et al., 2010; Östlin et al., 2011). So long as adequate support is not available for research that specifically addresses social determinants of health, “biomedical individualism” (Baum, Bégin, Houweling, & Taylor, 2009, p. 1968-9) will dominate discussions of how to reduce health inequity. The annual budget of the Ottawa Hospital Research Institute, one of the medium-sized city’s several hospital-based research units, is $113.7 million a year, for “bringing you tomorrow’s health care today,” in the words of the OHRI web site. Four-fifths of that budget comes from external sources (grants, contracts, and salary awards); we doubt that the annual value of external research support for social determinants of health in the entire country is that high. The point is not that less should be spent on research to improve patient care, but that budgets like that of the Canadian Institutes of Health Research continue to devote the lion’s share of funding to biomedical and clinical research (see Edwards, 2011, slide 44), creating a situation in which the body of evidence that many knowledge users will demand before acting on strategies to reduce health inequity simply will not be generated.
Next steps: Breaking down silos, reframing health disparities

As an oversimplification, two distinctive perspectives (which are not mutually exclusive) emerge from discussions on how the social determinants of health agenda can be moved forward. One emphasizes reorganizing public sector institutions and processes around concepts like intersectoral action, health in all policies – the focus adopted by Finland during its rotating presidency of the European Union in 2006 (Ståhl, Wismar, Ollila, Lahtinen, & Leppo, eds. 2006) - or a whole-of-government approach. Although nuances are many, at the core of each of these concepts is the idea that a lack of coordination among the various departments, agencies and ministries of government – sometimes referred to as policy coherence – impedes action on policies outside the health care system that have implications for health inequities.

The ‘silo problem’ is a defining characteristic of contemporary government organization. Less often acknowledged is the fact that many of the largest silos, with the strongest walls, are defined and defended by relations with powerful client groups outside government – think of ministries of agriculture, transportation, industry, or for that matter health (care). Social policy ministries and agencies, by contrast, seldom if ever have a comparably cohesive or influential clientele. The economic management role of ministries of finance and their lead role in public budgeting automatically confers special importance in an “unequal structure of representation” within government (Mahon, 1977). Further, it has been pointed out that policy coherence need not advance health equity; it is equally possible for policies to cohere around themes or priorities that are inimical to health equity (Labonté, Schrecker, & Sanders, 2008), as has been the case with neoliberal policy regimes in countries rich and poor alike. The WHO Euro review of the health divide is emphatic about the need to integrate “the views of ministers of health and social affairs” into economic and fiscal policy, specifically in the current context of austerity (Marmot et al., 2012). This proposal is laudable for the understanding it reveals of the health impacts of economic policy, which is a central theme of the review; disturbingly, has been noted that “public health voices have been largely absent from the debate” about responses to the financial crisis in Europe (Karanikolos et al., 2013, p. 1329). At the same time, it is not clear
that being 'at the table' will necessarily make a difference given the unequal structure of representation (and the shift of power from elected governments to financial markets that is a defining characteristic of contemporary globalization), or whether health ministries have either the capacity or the commitment to advance health equity in a way that goes beyond the narrowly behavioural.

A second perspective looks outside government, and emphasizes the need to build widespread support for action on social determinants of health. Policy change and new initiatives to address the underlying causes of health disparities will rarely if ever be achieved simply by assembling evidence, however compelling, that social conditions contribute to health disparities. Sir Michael Marmot has said that “a social movement to advance the cause of health equity through action on the social determinants of health” was one of the objectives of the Commission he chaired (Marmot et al., 2010). Although a detailed discussion of the characteristics of successful social movements and the conditions for their formation – an entire subfield of sociology – is outside the scope of this paper, it is worth noting that many recent social movements specific to health (Archibald & Crabtree, 2010; Brown, Adams, Morello-Frosch, Senier, & Simpson, 2010) have been defined by a specific condition or exposure, which provides a link among participants who may not otherwise be similarly situated. Social movements concerned with health equity and social determinants of health, on the other hand, may lack such ‘natural’ constituencies, complicating the task of building the necessary coalitions and mobilizing their support.

The tendency of biomedical individualism to dominate many popular understandings of disease causation and responsibility for illness (see e.g. Robert, Booske, Rigby, & Rohan, 2008) creates a further obstacle.

Here, insights from communications research are likely to be especially valuable (see generally Niederdeppe, Bigman, Gonzales, & Gollust, 2013), and the concept of framing is central. Framing refers to the way in which an issue is presented (see Lakoff, 1996). For example, presenting a taxation issue in terms of “tax burden” will encourage a different view on the issue than referring to “taxes for education.” Dorfman, Wallack, & Woodruff (2005) distinguish two kinds of frames: conceptual frames (those we use to make sense of the world) and news frames (those the mass media use to make sense of it for us). The use
of a few words can evoke an entire conceptual framework. For example, when business refers to legislation that might reduce its profits or freedom of action as a “job killer,” the effect is to activate a frame associated with danger and the need for immediate action; this immediate reaction will colour any debate on the issue and may even preclude meaningful discussion (Dorfman et al., 2005, p. 324). Conversely, a few carefully chosen words can also foreground the benefits of a proposed action or policy shift. Thus, a recent news story on finding new revenue sources for public transportation in the Greater Toronto Area leads with a reference to “fund[ing] a war on the traffic congestion that’s sapping the region’s prosperity,” with the specifics (which will inevitably involve added costs) relegated to the following paragraph.

In the context of social determinants of health, frames that involve attributions of responsibility are especially important (Niederdeppe, Bu, Borah, Kindig, & Robert, 2008). To the extent that health and illness are seen as consequences of individual choices, rather than as consequences of a social and economic environment in which the opportunities to lead a healthy life are distributed unequally, health disparities are less likely to be viewed as an important issue that merits policy attention, and lifestyle drift is likely to be pervasive. Many participants in workshops on an earlier draft of this paper emphasized the need to shift public opinion and perceptions away from an emphasis on individual responsibility for health and illness – in the words of one participant, “de-villainizing” people who are, for example, overweight or obese. As noted earlier, it is increasingly recognized by researchers that the pathways leading to overweight and obesity are multiple, complex, and involve such factors as income distribution, various aspects of the built environment, and the marketing strategies of the food and beverage industries (Glickman, Parker, Sim, Cook, & Miller, eds. 2012; Shih, Dumke, Goran, & Simon, 2012; Moodie et al., 2013). Thus, “a short-term goal of population health researchers and advocates should be to convey to both key stakeholders (policymakers, opinion leaders) and the broader public that health is produced by not only access to health care and individual health behaviors but also other social and economic factors such as poverty, education, and racial discrimination” (Niederdeppe et al., 2008, p. 483).
Even when public policies are apparently grounded in that understanding, they may not be coherent or effective. In the United Kingdom post-1997, the Labour government committed itself to reducing socioeconomic disparities in health, and indeed allocated substantial resources to the task. Despite successes like reducing child poverty (Waldfogel, 2010), as noted earlier by 2010 health disparities between rich and poor districts were, on many measures, greater than at any point since the Great Depression (Thomas et al., 2010) – this before the impact of post-crisis austerity measures. Johan Mackenbach (2010; 2011) explains the outcome partly in terms of poor selection of targets and strategies and the difficulty of reversing the cumulative impact of decades of disadvantage, but also by arguing that the degree of redistribution needed would never command the requisite electoral support. Indeed, the 2010 victory of the Conservatives could be read as vindicating Mackenbach’s view of the extent of electoral resistance to even modestly redistributive policies. If one accepts that reading, the question of why there should be such resistance nevertheless remains. Clearly, the wealthy who would lose from such redistribution are abundantly endowed with resources for resistance, but at best this provides only a partial explanation for the apparent unviability of policies from which a majority of the population would probably gain, in material terms.

Here again, attributions of responsibility are important. In the British context about which Mackenbach was writing, Owen Jones (2011) notes the emergence, starting in the 1980s, of a political culture that embraced “aspiration” and presumed that if not wealth, then at least a comfortable middle-class existence was available to anyone willing to work hard. He argues that this presumption was assiduously cultivated by the media, yet is increasingly at odds with the realities of deindustrialization and the spread of low-wage, precarious employment; growing inequality in access to education; and the erosion of various forms of social protection – ironically, on the watch of the same Labour government that was targeting health inequalities. Thus, the poor and marginalized were and are increasingly viewed as the authors of their own economic misfortune, and their situation not a matter for serious public concern except to the extent that their claims on the public treasury are called into question.
Whether or not one agrees with Jones’s eloquent analysis of the specifics of the British case, the analytical point and the implications for advancing health equity are clear. Making the case that health is related to social and economic factors, and challenging lifestyle drift at the level of intervention design, are not enough. It is also essential to question the presumption that people’s social and economic position is a consequence of their own efforts and initiative – or, conversely, of their lack of ‘personal responsibility’ – rather than of a background set of conditions in which “[t]he inequality machine is reshaping the whole planet” (Halimi, 2013). Deindustrialization and, more recently, the financial crisis of 2008 and its aftermath should have underscored the reality that people’s social and economic position and life chances are often the result of choices made and processes operating entirely outside their control. (Where ‘choices’ exist, they may look a lot like the one offered the workers at Electro-Motive.) Questioning what Jones calls a pernicious “doctrine of personal responsibility” (p. 183) may take many health practitioners and researchers far outside their comfort zone, but in the absence of such questioning – and the development of communication strategies to challenge the relevant conceptual and news frames as they are embedded in a broader political culture – it is hard to see how the social determinants of health agenda can be revitalized.
References


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