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Better Health:

An analysis of public policy and programming focusing on the determinants of health and health outcomes that are effective in achieving the healthiest populations

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KEY MESSAGES

- Although major health inequalities exist in Canada, minimal action has been taken by municipal, provincial/territorial and federal levels of governments to narrow health inequalities through the social determinants of health (SDOH) and public policy.
- Income, housing, food insecurity and social exclusion are four major social determinants in generating and reproducing health inequalities over the life course (childhood, adulthood and the elderly stage).
- Low-income individuals and families have significantly higher rates of mortality, morbidity and healthcare use as compared with middle- and high-income groups. Health inequalities between the richest 20% and the poorest 20% have decreased from 1971 to 1996 in Canada; however, continued monitoring is needed given that income inequality has increased over the past decade.
- Food insecurity and unstable housing are associated with poor health and, in turn, mediate the link between income and health (hunger and unstable housing affect health and result from low income). Mortality rates among homeless and marginally housed individuals were much higher than expected on the basis of low income alone.
- Social exclusion is a powerful determinant of health inequalities; however, its effects are dependent upon which groups are compared. The health consequences of social exclusion are most unequal between Aboriginal and non-Aboriginal groups. Immigrant health favours recent arrivals over long-term residents. Compared with non-minority ethnic groups, minority racial/ethnic groups are more likely to experience social and health disadvantages. However, no clear association exists for health inequalities between minority racial/ethnic groups.
- Taking action on SDOH to narrow health inequalities offers new opportunities for the nursing profession to expand its role to include:
 - supporting initiatives that reduce child and adulthood poverty levels by increasing financial assistance and social wages (SDOH provided through public funds)
 - supporting initiatives that increase minimum wages to “living wages” to ensure that economic security, stable housing and food needs are met
 - supporting campaigns and social movements that advocate for progressive taxation, the right to food security and affordable housing, and the enforcement of laws that protect the rights of socially excluded groups
 - advocating for intersectoral action on health at municipal, provincial/territorial and federal levels of government to coordinate action undertaken by sectors outside the health sector
 - supporting political parties at provincial/territorial and federal levels of government that are receptive to taking action on SDOH (such as those that are pro-labour or pro-redistribution of wealth)
 - encouraging greater workplace democracy to increase the number of unionized workplaces since labour unions are important determinants of generous welfare states, narrower social inequalities and better population health

EXECUTIVE SUMMARY

The World Health Organization's Commission on Social Determinants of Health (CSDH), *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health*, confirmed that “social justice is killing people on a grand scale” and that public policy action has the potential to narrow avoidable health inequalities. Although major health inequalities exist in Canada, minimal action has been taken by municipal, provincial/territorial and federal levels of governments to reduce these through the social determinants of health (SDOH).

To advance the role of nursing in reducing health inequalities, this paper conducts a scoping review to *assess the empirical association between social determinants and health outcomes and to identify public policies and political activities that reduce health inequalities*. Guided by the CSDH's conceptual framework, which emphasizes the “causes of the causes” to reduce social inequalities in health, this paper moves beyond the consideration of immediate causes such as medical treatments or lifestyle choices.

Three questions are addressed:

- What is the current scope of knowledge from Canadian research on SDOH, conceptualized as income, housing, food insecurity and social exclusion?
- What is the role of nursing in reducing health inequalities within Canada's political and economic contexts?
- Which policy recommendations have the potential to narrow health inequalities?

Scoping review methods consisted of five steps. First, the electronic database PubMed was searched using these keywords: “income” or “food insecurity” or “housing” or “social exclusion” and “population health” or “health inequalities” and “Aboriginal Peoples” or “First Nations” or “Métis” or “Inuit” and “Canada”. Second, we screened potentially relevant studies and included them if the studies presented empirical findings and tested at least one SDOH measure. Third, we charted descriptive and empirical data using a coding template. Fourth, studies grouped by theme were coded as *positive* (social determinant of health is positively associated with health), *negative* (social determinant is inversely associated with health), *mixed* (social determinant is inconsistently related to health) or *no impact* (relation between social determinant and health is not significant). Effect size metrics were also extracted to compare the strength of associations between social determinants and health-related outcomes. Fifth, we searched government reports, international commissions and cost-benefit analyses to augment and inform our policy recommendations.

Current scope of SDOH research in Canada

A total of 109 studies met our inclusion criteria (income, n = 65; food insecurity, n = 6; housing, n = 9; social exclusion, n = 11; multiple SDOH, n = 18). Our central finding indicates a large, negative and statistically significant association between social determinants and health inequalities.

The association between income and health follows a clear gradient. Low-income Canadians have the highest rates of mortality, morbidity and healthcare use, and middle-income individuals and families have worse health outcomes as compared with the highest income groups. These findings remain significant regardless of whether income is measured at individual, household or neighbourhood levels. Despite non-significant results in the past, recent research finds that income inequality is an independent contributing factor to mortality in Canadian-born individuals but not immigrants.

Health inequalities between the richest 20% and the poorest 20% decreased from 1971 to 1996 in Canada. This encouraging trend needs monitoring given that income inequality has increased over the past decade. Canada's inclusive healthcare system appears to attenuate the impact of low income on health (for example, breast cancer survival).

Food insecurity and unstable housing are strongly associated with health inequalities and mediate the link between low income and health. As a result, hunger and unstable housing are often caused and exacerbated by low economic resources.

The health consequences of social exclusion are most unequal between Aboriginal and non-Aboriginal groups. Research findings support the "healthy immigrant effect," in that recent immigrants are healthier compared with long-term immigrant residents. Compared with non-minority ethnic groups, minority racial/ethnic groups are more likely to experience social and health disadvantages; however, no clear association exists for health inequalities between minority racial/ethnic groups.

Role of nursing in reducing health inequalities

Our scoping review results confirm the importance of low income, unstable housing, food insecurity and social exclusion in generating health inequalities in Canada. Taking action on these SDOH requires the collaboration of various government, civil and health actors. This collaboration introduces new opportunities for the nursing profession to expand its role to include advocacy, policy analysis and political activities. Support for nurses to engage in public health action includes theoretical and professional justifications.

Recent theoretical thinking calls upon nurses to uphold an "emancipatory ethic" and to apply a "critical care" perspective. The former involves identifying with socially excluded groups (for example, Aboriginal groups), challenging mechanisms of oppression (such as the legacy of colonization) and becoming active social change agents. The latter reincorporates the value of social justice that was characteristic of early public health nursing practice. Applying a critical care perspective challenges nurses to play an integral role in reducing health inequalities by engaging in political and economic environments and advocating through policy analysis, development and implementation.

Expanding the role of nurses to engage in SDOH has been documented in the profession's standards and competencies. Public health nurses have argued that practitioners have a professional obligation to engage in socio-political activities that improve the social conditions associated with health inequalities. On a similar yet stronger note, community health nurses in Canada have identified the reduction of health inequalities arising from social inequalities as a *practice standard* and *core competency* for nursing practice. Such a commitment requires nurses to address the root causes of health inequalities, identify which SDOH require action, uphold the principles of social justice and engage in advocacy in support of the most disadvantaged groups.

Policy recommendations to narrow health inequalities

To advance the role of nursing in narrowing health inequalities through public policy, we provide both specific and wide-ranging policy recommendations regarding SDOH to encourage intersectoral action at different levels and in different sectors of government:

- Support initiatives that reduce child and adulthood poverty by increasing financial assistance and social wages (SDOH provided through public funds). Target efforts toward groups most likely to be affected by poverty, including Aboriginal Peoples, the homeless, single mothers and their children, persons with disabilities, minority racial/ethnic groups, and recent immigrants. International evidence suggests that levels of poverty are highly amenable to public policy initiatives.
- Support initiatives that increase minimum wages to “living wages” to ensure that basic income, housing and food needs are met. Although living wage policies are relatively new in Canada, they have been implemented in the United States and the United Kingdom. Comparative evidence suggests that increasing wages to living levels leads to substantial improvements in health.
- Support campaigns and social movements that advocate for progressive taxation, the right to food security and affordable housing, and the rights of socially excluded groups to be protected (for example, in areas of employment, anti-discrimination and anti-racism).
- Advocate for intersectoral action on health inequalities at municipal, provincial/territorial and federal levels of government to coordinate SDOH policies. Given that public policies targeted at income, housing, food insecurity and social exclusion fall outside the health sector, intersectoral action is needed to effectively coordinate activities to narrow health inequalities.
- Support candidates and political parties at provincial/territorial and federal levels of government that are receptive to taking action on SDOH (such as those with pro-labour and leftist ideology). Comparative evidence finds that left-leaning political parties are more likely to support social democratic principles of equality such as poverty reduction.
- Encourage greater workplace democracy to increase the number of unionized workplaces. Labour unions are an effective mechanism for increasing wages and worker bargaining power, redistributing income, and improving employment security and occupational health standards.