Latest OECD Figures Confirm Canada as a Public Health Laggard

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ABSTRACT

Despite the Canadian public health community's commitments to promoting public policy that supports health, evidence indicates that Canada's public health picture continues to decline. This may be due in part to the failure of public health agencies and local public health units to engage in public policy advocacy and public education about the social determinants of health. Examples of such activities by local public health units are now available and provide a model for such activity.

Key words: Public policy; public health; community development

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The Canadian public health community recognizes, but has been limited in applying, the social determinants of health (SDOH) concept in its work.¹ A consensus now exists that living and working conditions – the primary determinants of health – should inform the activities of public health agencies and local health units.^{2,3} Three roles are commonly identified: a) reporting the state of the SDOH in Canada and local communities; b) modifying public health programs to recognize the particular needs of disadvantaged groups; and c) engaging with community partners in local actions to strengthen the SDOH.⁴ There is rather less consensus on whether public health agencies and local health units should be involved in public policy advocacy,^{1,4,5} that is, efforts to influence policies, statements, and practices by authorities through various forms of persuasion.⁶

The failure of the public health community to engage in public policy advocacy is problematic as it is increasingly being recognized that the SDOH are shaped by public policy decisions made by governmental authorities.^{3,7,8} Further, it appears the decisions being made by Canadian governments are increasingly threatening, rather than promoting, public health.^{9,10}

The World Health Organization sounds this warning about the growing inequities regarding the SDOH: "This 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."^{8, p.1} What is the latest evidence concerning Canada's provision of the SDOH through its public policies and what are the implications for the public health community?

Welfare state policy and public health

Despite calls by the business community¹¹ and conservative media^{12,13} to weaken the size and strength of the welfare state, it appears that a strong welfare state is an important determinant of a society's overall health and quality of life.^{14,15} Nevertheless, for decades Canadian leaders have been bent on reducing the size and strength of the Canadian welfare state.¹⁶⁻¹⁸ Our relative declines in

standing on numerous health and quality of life indicators have been the result.

Statistics in *Society at a Glance: 2011 OECD Social Indicators* and *Health at a Glance: 2011 OECD Health Indicators*, reports published by the Organisation for Economic Co-operation and Development (OECD), bring to light Canada's mediocre and weakening performance in developing public policy that promotes health.^{19,20} Evidence is available in three key areas: governmental spending on social provision, income inequality and poverty, and health outcomes.

It is documented by the OECD,²⁰ UNICEF,²¹ and the Conference Board of Canada in its annual report cards on Canada's performance²² that societies whose governments expend greater resources on social provision in the form of public services and citizen benefits (e.g., provisions to families, seniors, persons with disabilities, and unemployed workers) have less income inequality, lower poverty rates, and better overall health and quality of life. In 2007, Canada ranked only 23rd of 34 OECD nations in social provision, allocating only 16.9% of GDP to these supports. The OECD average was 19.3%.²⁰ In 1980, Canada's spending of 13.7% gave it a rank of 17th of 24.

Not surprisingly, Canada compares unfavourably to other OECD nations in income inequality and poverty rates. Where 1st is the best ranking and 34th the worst, during the late 2000s Canada ranked 22nd of 34 OECD nations in income inequality and 21st of 34 nations in poverty rate, compared to 10th of 22 and 14th of 21, respectively, in the mid-1980s.²⁰ Canada's income inequality and relative ranking declined since the 1980s while its poverty rate and relative ranking was stable. Income inequality – the gaps among the population in economic resources – undermines societal cohesion and is related to a range of indicators of societal dysfunction.²³

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Poverty rate identifies the proportion of the population at significant risk for a wide range of health problems across the lifespan.²⁴

For health outcomes, using the same “first is best” metric, in 2008 Canada ranked 27th of 34 nations in infant mortality rate, the measure generally seen as the overall best indicator of population health.^{19,25} Remarkably, Canada was ranked 10th of 24 nations in infant mortality in 1980.²⁶ This shift downward is a result of Canada’s decline of 3.4/1000 in infant mortality rates since 1980 being the smallest among OECD nations.¹⁹ Canada’s rank of 10th of 34 OECD nations in life expectancy represents a decline in rank from 7th in 1990 (Canada was 8th in 1980).²⁶ Canada’s increase in life expectancy of 4.5 years since 1983 was well below the OECD average increase of 6.0 years. The USA – increasingly a model for Canadian public policy-making^{27,28} – showed the smallest increase in life expectancy since 1983.¹⁹

The evidence suggests that Canada’s mediocre health outcomes reflect its continuing to expend less resources towards citizen supports than other OECD nations.²⁰ This trend will accelerate with continuing implementation of the majority Conservative government’s agenda in Ottawa.²⁹ Continuing declines in relative standings in population health as compared to other OECD nations can be expected. Where does the public health community fit into all of this? The answer is rife with contradictions.

At one level, CPHA’s public policy statements over decades have been in the forefront in emphasizing the links between public policy, the determinants of health, and health outcomes.⁷ But it has also been acknowledged that these policy statements have not been well communicated to the public nor have they had much impact on Canadian policy-making.⁹

At first glance, recent reports by Canada’s Chief Health Officer and many provincial ministries of health appear attentive to these important issues.^{25,30,31} Closer analysis, however, reveals that the role of governmental public policy-making is avoided and reports instead focus on community and local action rather than public policy advocacy.³² These actions include the establishment of children’s feeding programs, food banks, local literacy programs, parenting programs, and other community-based programs that “[A]re unable to address the structural determinants of health inequalities.”^{32, p.94}

Finally, with few exceptions, studies demonstrate a failure on the part of public health agencies and local public health units to engage in the sphere of public policy advocacy for action on the SDOH.^{4,5}

The way forward

The reasons why the public health community has failed to engage in public policy advocacy have been theorized to include fear of political retribution in the form of budget cuts, confusion about the appropriate role for public health agencies and units, and lack of training in public policy analysis.³³ A way to avoid direct involvement in public policy advocacy but to build impetus for such action is through public education. By raising awareness and building knowledge about the broader SDOH, the groundwork can be laid such that public policy advocacy undertaken by public health departments and local health units will have the support of local residents and governments. It may also lead to local residents themselves becoming engaged in advocacy activities through local organizations. But similar to the situation regarding public policy

advocacy, these activities among public health agencies and local health units are rare.⁴

The failure of the public health community to engage in public policy advocacy and public education essentially condones observed health inequalities as well as the public policies associated with these inequalities. And the public health communities’ claim to protect and promote the health of Canadians is rendered mere rhetoric.^{7,34}

Fortunately, some excellent examples now exist of local public health units carrying out public policy advocacy and public education: newspaper ads by a local public health unit calling for a conversation about the SDOH;³⁵ public service messages appearing on television;³⁶ and a public health unit’s video animation on the SDOH and their relation to public policy-making³⁷ that has been adapted for use by 10 other local health units and is being considered by at least another 10. An ongoing study of how public health units address the SDOH found these animations helped to: a) explain these issues to local elected representatives, and b) build public support for these units’ advocacy activities.³⁸

These and other examples show how the public health community can play a role in stimulating public discussion of the links between the changing Canadian welfare state, related public policy-making, and the health of Canadians. These activities can be modeled by public health agencies and local units. The desired outcome of such activities is Canadian governments creating public policy that promotes, rather than threatens, public health.³⁹

Realization of the statement “Canadian Public Health Association members believe in universal and equitable access to the basic conditions which are necessary to achieve health for all Canadians”³⁴ therefore requires that public health agencies and local health units communicate to governmental authorities and the public what is known about the SDOH and insist upon the making of health-promoting public policy. Are Canadian public health agencies and local health units willing to engage in these activities? If not, are they prepared to live with the public health consequences?

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RÉSUMÉ

Bien que la communauté de la santé publique se soit engagée à promouvoir les politiques publiques qui favorisent la santé, il est prouvé que le portrait de la santé publique au Canada continue à se détériorer. Cela s'expliquerait en partie par le fait que les organismes de santé publique et les bureaux de santé publique locaux ne mènent pas d'activités de défense des politiques publiques ni de sensibilisation aux déterminants sociaux de la santé. Des exemples de telles activités par des bureaux de santé publique locaux sont maintenant disponibles et offrent un modèle à suivre.

Mots clés : politique publique; santé publique; développement communautaire