

# A Discourse Analysis of the Social Determinants of Health

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## Abstract

The social determinants of health (SDH) concept is common to numerous Canadian policy documents and reports. Yet there has been little effort made to implement their implications in public policy. Much of this has to do with the SDH concept being in conflict with current governmental approaches that reflect welfare state retrenchment and deference to the dominant societal institution in Canada, the marketplace. An additional problem is that even among SDH researchers and those attempting to implement SDH-related concepts, there is a reluctance to identify the public policy implications of the SDH concept. The result is the presence of a variety of SDH discourses that differ greatly in their explication of the SDH concept and their implications for action. This paper identifies these various SDH discourses with the goal of noting their contributions and limitations in the service of advancing the SDH agenda in Canada and elsewhere.

## Introduction

With the publication of the Commission on the Social Determinants of Health's final report and those of its knowledge hubs, the social determinants of health (SDH) concept has achieved a status that makes it difficult for policymakers and health researchers and professionals to ignore (Commission on the Social Determinants of Health, 2008). This has certainly been the case in Canada where the SDH figure prominently in health policy documents produced by the Federal government (Public Health Agency of Canada, 2007, 2008), the Chief Health Officer of Canada (Butler-Jones, 2008), the Canadian Senate (Senate Subcommittee on Population Health, 2008), numerous public health and social development organizations and agencies (Canadian Public Health Association, 2008; Chronic Disease Alliance of Ontario, 2008; United Nations Association of Canada, 2006), research funding agencies (Canadian Institutes of Health Research, 2005; Institute of Population and Public Health, 2003), and even the business-oriented Conference Board of Canada (Conference Board of Canada, 2008).

The content of these documents is consistent with the view that a) SDH are important influences upon the health of individuals, communities, and jurisdictions as a whole and b) SDH

represent the quantity and quality of a variety of resources a society makes available to its members. Most imply that something should be done to strengthen them.

It is well documented however that actual implementation of these concepts in Canada lags well behind other jurisdictions (Canadian Population Health Initiative, 2002; Lavis, 2002; Raphael, Curry-Stevens, & Bryant, 2008). The SDH concept – and their public policy implications – conflict with current governmental approaches that reflect welfare state retrenchment and deference to the dominant societal institution in Canada, the marketplace (Raphael & Bryant, 2006). The result is Canada’s *reputation* as a “health promotion and population health powerhouse” (Raphael, 2008a; Restrepo, 1996) with the actual *reality* being one of increasing social and economic inequalities, deteriorating quality SDH, and decaying health status and quality of life (Bryant, Raphael, Schrecker, & Labonte, 2009).

An additional problem is that SDH researchers and those attempting to implement SDH-related concepts are reluctant to identify the public policy implications of the SDH concept (Raphael et al., 2004). There is an even greater reluctance to consider the political and ideological sources of the inequitable distribution of SDH quality among Canadians (Raphael, 2006). The result is the presence of a variety of SDH discourses that differ greatly in their explication of the SDH concept and their implications for action. In this article, I identify these various discourses and by noting their contributions and limitations, aim to advance the SDH agenda in Canada and elsewhere.

### Social Determinants of Health Discourses

SDH refer to the societal factors – and the unequal distribution of these factors -- that contribute to both the overall health of Canadians and existing inequalities in health (Graham, 2004a). Since the modern introduction of the term SDH (Tarlov, 1996), a variety of conceptualizations – all clearly referring to societal factors -- have appeared (Table 1).

Ottawa Charter <sup>1</sup>	Dahlgren and Whitehead <sup>2</sup>	Health Canada <sup>3</sup>	World Health Organization <sup>4</sup>	Centers for Disease Control <sup>5</sup>	Raphael et al. <sup>6</sup>
Peace shelter education food income stable ecosystem sustainable resources social justice equity	agriculture and food production education work environment unemployment water and sanitation health care services housing	income and social status social support networks education employment and working conditions physical and social environments healthy child development health services gender culture	social gradient stress early life social exclusion work unemployment social support addiction food transport	socio-economic status transportation housing access to services discrimination by social grouping social or environmental stressors	Aboriginal status early life education employment and working conditions food security gender health care services housing income and its distribution social safety net social exclusion unemployment and employment security

<sup>1</sup> (World Health Organization, 1986)

<sup>2</sup> (Dahlgren & Whitehead, 1992)

<sup>3</sup> (Health Canada, 1998)

<sup>4</sup> (Wilkinson & Marmot, 2003)

<sup>5</sup> (Centers for Disease Control and Prevention, 2005)

<sup>6</sup> (Raphael, Bryant, & Curry-Stevens, 2004)

The evidence base in support of the importance of the SDH is now extensive (Commission on the Social Determinants of Health, 2008; Davey Smith, 2003; Wilkinson & Marmot, 2003). Among those researching and engaged in SDH-related activities, a consensus exists that non-medical and non-behavioural risk factors are worthy of attention. But I have observed profound differences in how this consensus plays out in research and professional activity. To my mind, this variation is not merely about *paradigms* that define intellectual world views about how such phenomena can be understood or investigated (Guba, 1990; Kuhn, 1970). This variation rather represents Foucaultian *discourses* which – since they involve issues of legitimating, power, and coercion -- exert a much more powerful influence upon research and practice (Foucault, 1972).

Indeed, numerous conversations with health researchers and professionals, as well as my own research funding experiences are consistent with the hypothesis that these SDH discourses direct the kinds of research and professional activities that are deemed acceptable, i.e, fundable in the case of research and institutional budgeting, and career-enhancing in terms of personal futures. For many, expressing a more critical analysis of the SDH is seen as career-threatening.

Table 2. SDH Discourses			
SDH Discourse	Key Concept	Dominant Research and Practice Paradigms	Practical Implications of the Discourse
1. SDH as identifying those in need of health and social services.	Health and social services should be responsive to peoples' material living circumstances.	Develop and evaluate services for those experiencing adverse living conditions.	Focus limited to service provision with assumption that this will improve health.
2. SDH as identifying those with modifiable medical and behavioural risk factors.	Health behaviours (e.g., alcohol and tobacco use, physical activity, and diet) are shaped by living circumstances.	Develop and evaluate lifestyle programming that targets individuals experiencing adverse living conditions.	Focus limited to health behaviours with assumption that targeting for behaviour change will improve health.
3. SDH as indicating the material living conditions that shape health.	Material living conditions operating through various pathways – including biological -- shape health.	Identify the processes by which adverse living conditions come to determine health.	Identifying SDH pathways and processes reinforce concept and strengthen evidence base.
4. SDH as indicating material living circumstances that differ as a function of group membership.	Material living conditions systematically differ among those in various social locations such as class, disability status, gender, and race.	Carry out class-, race-, and gender-based analysis of differing living conditions and their health-related effects.	Providing evidence of systematic differences in life experiences among citizen groups form the basis for further anti-discrimination efforts.
5. SDH and their distribution as results of public policy decisions made by governments and other societal institutions.	Public policy analysis and examination of the role of politics should form the basis of SDH analysis and advocacy efforts.	Carry out analyses of how public policy decisions are made and how these decisions impact health (i.e., health impact analysis).	Attention is directed towards governmental policymaking as the source of social and health inequalities and the role of politics.
6. SDH and their distribution result from economic and political structures and justifying ideologies.	Public policy that shapes the SDH reflects the operation of jurisdictional economic and political systems.	Identify how the political economy of a nation fosters particular approaches to addressing the SDH.	Political and economic structures that need to be modified in support of the SDH are identified.
7. SDH and their distribution result from the power and influence of those who create and benefit from health and social inequalities.	Specific classes and interests both create and benefit from the existence of social and health inequalities.	Research and advocacy efforts should identify how imbalances in power and influence can be confronted and defeated.	Identifying the classes and interests who benefit from social and health inequalities mobilizes efforts towards change.

In the following sections I examine the contribution – and deficiencies -- of the various SDH discourses and how they may play out in SDH research activity and professional practice.

#### Discourse 1. SDH as Identifying those in Need of Health and Social Services

In this discourse individuals and communities who experience adverse SDH are recognized as having a greater incidence of a variety of medical and social problems. In response, the health and social service needs of these individuals are identified and appropriate services delivered. Some examples of this include addressing the health care needs of homeless individuals, effectively managing of chronic diseases within vulnerable communities, and promoting screening and primary health care among immigrant groups among others (Benoit, Carroll, & Chaudhry, 2003; Hwang & Bugeja, 2000; Saxena, Majeed, & Jones, 1999; Sword, 2000). Public health agencies can provide preventive health services and social service agencies can provide supports to SDH-deprived individuals.

The provision of responsive health and social services is important. But limiting research and professional activity to developing and implementing such programs can neglect the sources of these afflictions – i.e., poor quality SDH -- doing little to reduce the need for these services. This discourse can reinforce already dominant health care and social service emphases, thereby obscuring the importance to health of the SDH and their inequitable distribution.

#### Discourse 2. SDH as Identifying those with Modifiable Medical and Behavioural Risk Profiles

The “healthy lifestyles” SDH discourse recognizes that individuals and communities experiencing adverse SDH exhibit an excess of medical (e.g., high sugar and “bad” cholesterol levels, etc.) and behavioural (e.g., poor diet, lack of physical activity, and tobacco and excessive alcohol use) risk factors. Here, the SDH represent a set of adverse living conditions that direct attention to modifying risk behaviours among those experiencing adverse SDH (Allison, Adlaf, Ialomiteanu, & Rehm, 1999; Choi & Shi, 2001; Choiniere, Lafontaine, & Edwards, 2000; Potvin, Richard, & Edwards, 2000).

Unlike Discourse 1 which stresses provision of health and social services to those experiencing poor quality SDH, this discourse and its implementation has significant negative aspects. First, these risk factors account for relatively little of the variation in health outcomes as compared to the experience of poor quality SDH (Lantz et al., 1998; Raphael, Anstice, & Raine,

2003; Raphael & Farrell, 2002). Second, it is embedded within a framework that assumes that individuals are capable of “making healthy lifestyle choices” such that individuals who fail to do so are responsible for their own adverse health outcomes (Labonte & Penfold, 1981; Lindbladh, Lyttkens, Hanson, & Ostergren, 1998; Raphael, 2002).

Third, these programs show rather little evidence of effectiveness serving only to further disenable vulnerable populations and the health workers administering these programs (O'Loughlin, 2001; Raphael, 2002). Finally, they have a disturbing tendency to neglect the sources of the adverse SDH to which individuals are exposed, further obscuring their importance (Raphael, 2003).

### Discourse 3. SDH as Indicating the Material Living Conditions that Shape Health

Here, there is clear recognition that adverse SDH themselves are important influences upon health and that various pathways exist by which adverse quality SDH “get under the skin” to shape health. In one model, interacting material, psychological, and behavioural pathways are identified that reflect the influence of societal structures (broadly defined), employment and working conditions, and neighbourhood characteristics (Brunner & Marmot, 2006). Other models specify how exposures to poor quality SDH during childhood and adulthood interact to produce health outcomes across the life-span (Benzeval, Dilnot, Judge, & Taylor, 2001; van de Mheen, Stronks, & Mackenbach, 1998). Models identifying physiological processes by which SDH “get under the skins” are also an area of activity (Brunner & Marmot, 2006; Meany, Szyf, & Seckl, 2007; Sapolsky, 1992).

Extensive evidence of the importance for health of numerous SDH domains is available (Gordon, Shaw, Dorling, & Davey Smith, 1999; Marmot & Wilkinson, 2006; Raphael, 2008b). The clear message of this discourse is that adverse living conditions and their material, psychological, and behavioural effects – not the adoption of poor “lifestyle” choices – are the primary determinants of health.

Yet even this more mature SDH discourse is frequently diluted if the public policy antecedents of SDH are not emphasized. Governments and health and social service organizations and agencies can take information about the importance of early life, for instance, and translate this into promoting better parenting or having schools foster exercise among children rather than improving the provision of financial resources to those in need or providing

affordable housing. Authorities can implement breakfast programs, clothing and food drives, and coping or anger-management classes rather than considering how public policies create financial insecurity.

#### Discourse 4. SDH as Indicating Material Living Circumstances that Differ as a Function of Group Membership.

Much activity identifies how variations in the SDH and health status occur as a function of class, gender, and race (Dunn & Dyck, 2000; Galabuzi, 2004; McMullin, 2008; Ornstein, 2000; Pederson & Raphael, 2006; Wallis & Kwok, 2008). This work draws upon the extensive social inequalities literature and specifies how particular groups are exposed to poor quality SDH (Graham, 2004b, 2001). But like the previous discourse, this work lends itself open to the possibility -- if the public policy antecedents of the inequitable distribution of SDH are not emphasized -- of seeing the problem as being amenable to program interventions (e.g., literacy and counseling programs, anti-discrimination training, etc.) directed towards individuals or groups.

#### Discourse 5. SDH and their Distribution Results from of Public Policy Decisions Made by Governments and other Societal Institutions

As noted, SDH discourse can identify the relationship between a SDH and health status. In this discourse the analysis considers how SDH and their distribution come about as a result of public policy decisions. There is a clear assumption that the primary means of improving the SDH and promoting their more equitable distribution is through public policy activity (Armstrong, 1996; Bryant, 2006; Bryant et al., 2009; McIntyre, 2008; Shapcott, 2008; Tremblay, 2008). This discourse is well represented by the conclusions of the World Health Organization's Commission on the SDH (Commission on the Social Determinants of Health, 2008).

As an illustration of this discourse, the SDH of early life is shaped by availability of material resources that assure adequate educational opportunities, food and housing, among other SDH (Hertzman, 2000). Much of this has to do with parents' employment security, wages, and the quality of their working conditions and availability of quality, regulated childcare (Innocenti Research Centre, 2007). All of these SDH are shaped by public policy.

In Canada, Kirkpatrick and McIntyre comment on the reluctance to consider public

policy implications of the SDH apparent in the Chief Health Officer of Canada's (CPHO) report on health inequalities:

The CPHO report's failure to emphasize the essential role of government action is reinforced by the examples used to illustrate "successful interventions that... may serve to reduce Canada's health inequalities and improve quality of life for all Canadians" (p.1). In fact, the interventions highlighted tend to be community-based programs that are unable to address the structural determinants of health inequalities. (Kirkpatrick & McIntyre, 2009) p, 94

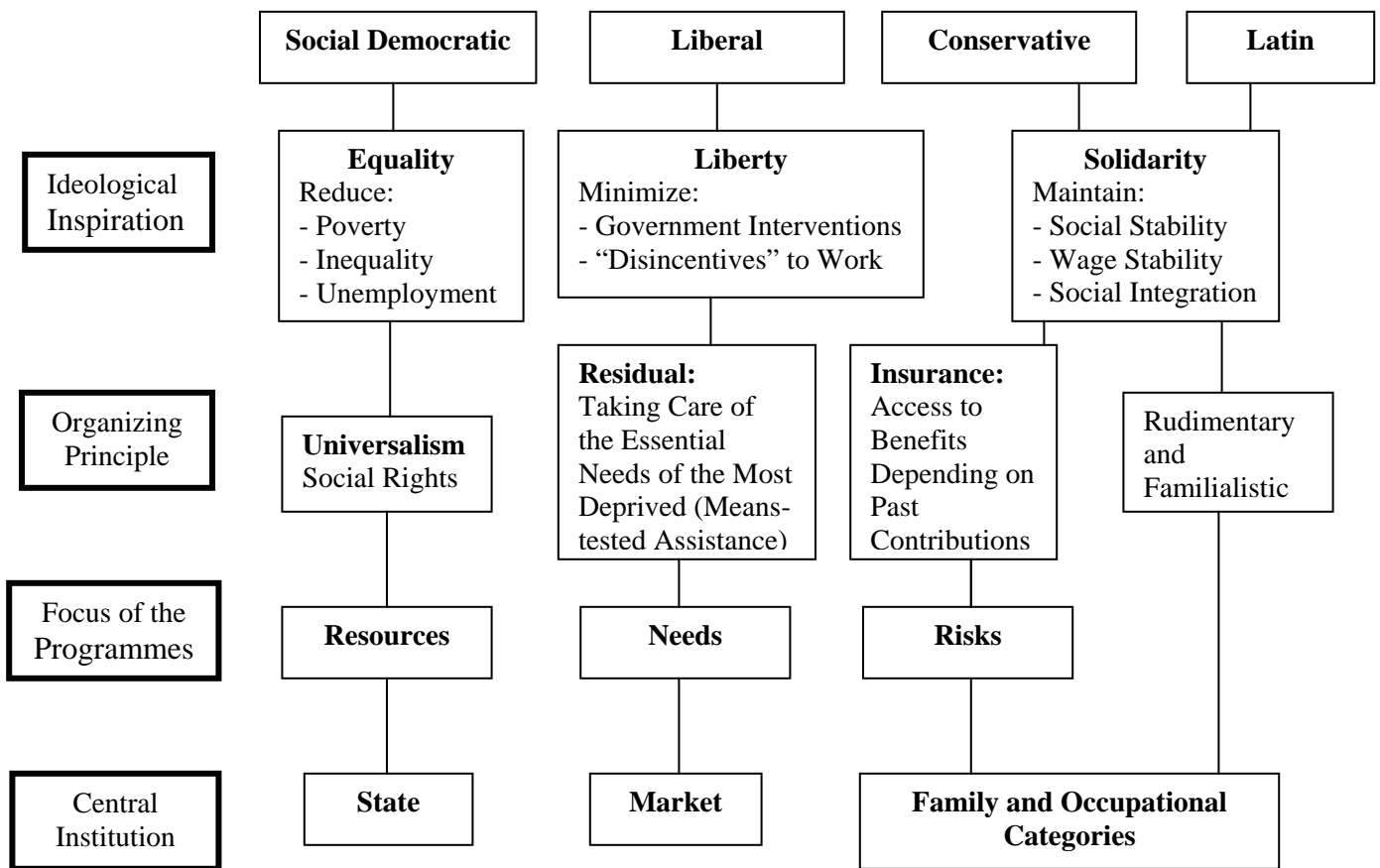
#### Discourse 6. SDH and their Distribution Result from Jurisdictional Economic and Political Structures and Justifying Ideologies

Identifying public policy antecedents of SDH and their distribution can promote and support public policy advocacy. But why is it that many nations have acted upon SDH-related evidence while others – such as Canada -- are identified as SDH policy laggards (Bryant et al., 2009)? In this discourse, consideration is given how a nation's historical traditions and economic and political structures support or hinder SDH-supportive public policies (Bambra, 2006; Bambra, Fox, & Scott-Samuel, 2005; Coburn, 2004; Navarro & Shi, 2002; Raphael & Bryant, 2006).

Jurisdictional approaches to SDH issues appear to cluster and appear amenable to a "worlds of welfare analysis" (Bambra, 2007; Eikemo & Bambra, 2008). In one prominent model, three distinct types of welfare states are identified: social democratic (e.g., Sweden, Norway, Denmark, and Finland), liberal (USA, UK, Canada, Ireland), and conservative (France, Germany, Netherlands, and Belgium, among others) (Esping-Andersen, 1990, 1999).

Two Canadian sociologists Saint-Arnaud and Bernard provide a graphic (that adds a 4<sup>th</sup> welfare state type) that suggests how differences in political and economic structures and processes (political economy) – themselves a result of historical traditions and governance by specific political parties over time -- are related to the SDH (Figure 1) (Saint-Arnaud & Bernard, 2003). The social democratic welfare states provide far superior quality SDH (e.g., equitable income distribution and low poverty rates, family supports including early education and care, living wages, employment, food, and housing security, extensive health and social services, etc.)

Figure 1: Ideological Variations in Forms of the Welfare State



Source: Saint-Arnaud, S., & Bernard, P. (2003). Convergence or resilience? A hierarchical cluster analysis of the welfare regimes in advanced countries. *Current Sociology*, 51(5), 499-527, Figure 2, p. 503.

than do liberal welfare states (Conference Board of Canada, 2003, 2006; Innocenti Research Centre, 2008; Navarro et al., 2006; Navarro & Shi, 2002; Organization for Economic Cooperation and Development, 2009; Raphael, 2007a). Not surprisingly, on numerous health and quality of life indicators the social democratic political economies outperform the liberal (Conference Board of Canada, 2003, 2006; Navarro et al., 2004).

Since the dominant inspiration of liberal political economies is to minimize governmental intervention in the operation of its central institution – the market – it should not be surprising that Canada – and its liberal partners – fall well behind other nations in addressing the SDH. It

should also not be surprising that Canadian public policy continues to be adverse to SDH-concepts. The discourse broadens analysis beyond simply identifying public policy implications to one of attempting to influence the political and economic structures that shape such policy.

### **Discourse 7. SDH and their Distribution Result from the Influence and Power of Those Who Create and Benefit from Social and Health Inequalities.**

*It is not inequalities that kill, but those who benefit from the inequalities that kill*

(Navarro, 2009) p.15.

In this final discourse the individuals and groups who through their undue influence upon governments create and benefit from social and health inequalities – and in the process weaken the SDH and skew their distribution -- are identified (Chernomas & Hudson, 2009; Kerstetter, 2002; Langille, 2008; Navarro, 2009; Scambler, 2001; Wright, 2003; Yalnizyan, 2007). These individuals and groups lobby for – and been successful in -- shifting the tax structures to favour the corporate sector and the wealthy, reducing public expenditures, controlling wages and employment benefits, and relaxing labour standards and protections (Chernomas & Hudson, 2009; Kerstetter, 2002; Langille, 2008; Navarro, 2009; Scambler, 2001; Wright, 2003; Yalnizyan, 2007). In Canada and elsewhere, these public policy changes have led to lead increasing income and wealth inequalities, stagnating worker incomes, and growing incidence of housing and food insecurity (Jackson, 2000; Kerstetter, 2002; Lee, 2007; Leys, 2001).

Who exactly are these villains (or *Greedy Bastards*, according to Scambler, 2001) and how can their undue influence upon public policy be resisted? Langille (2008) identifies business associations, conservative think tanks, citizen front institutions and conservative lobbyists. It is important to recognize that these individuals and groups are acting in their own interests and in parliamentary democracies they have every right to do so. In Canada, the problem is that as their power and influence has increased there has been a corresponding declining counterbalances to their influence (Langille, 2008; McBride & Shields, 1997).

What form might these counterbalances take? Langille (2008) and others propose educating the public and using the strength in numbers of the public to promote public policy that will oppose this agenda. Wright's argument for organizing to "oppose and defeat" the powerful interests that influence governments to maintain poverty can be applied to the SDH in

general (Wright, 1994, 2003). These defeats can occur in the workplace through greater union organization and increasing public recognition of the class-related forces that shape public policy.

Defeats can also occur in the electoral and parliamentary arena by election of political parties that favor public policy action to strengthen the SDH (Brady, 2003; Esping-Andersen, 1985). Internationally, it is well demonstrated that social democratic parties are more receptive to – and successful at -- to implementing SDH-supportive public policies (Brady, 2003; Navarro, 2009; Rainwater & Smeeding, 2003). In Canada, the NDP – in contrast to the Liberal and Conservative Parties – have policy positions more consistent with SDH-enhancing public policies (Raphael, 2007b). It was only upon the election of New Labour in the UK in 1997 that health inequalities began to be addressed.

### Conclusion

Efforts to strengthen the SDH through public policy activity in Canada lags well behind those seen in other developed nations. Governmental authorities are resistant to the SDH concept and public lack of awareness minimizes the likelihood that public pressure to address these issues will appear. Even within the SDH research and professional community there is resistance to exploring the public policy implications of SDH concepts. Various discourses that consider SDH but ignore their public policy antecedents allow governmental authorities to neglect the SDH and their inequitable distribution.

The last discourse proposes addressing these issues through public policy action in the political realm. To achieve this requires educating the public that deteriorating quality SDH and inequitable SDH distributions result from the undue influence upon public policymaking by those creating and profiting from social and health inequalities. In light of Canada's current economic and political structures, and the continuing influence of the corporate and business sector upon public policymaking, the possibility of achieving significant progress on SDH-related issues by working within the other discourses seems unlikely.

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