

Recommendations for action on the social determinants of health: a Canadian perspective

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Health disparities are widely prevalent within and between countries, and Canada is no exception.^{1,2} Although historic efforts to address such disparities have not been successful and Canada's provincial and territorial health goals have been only partly achieved,³ we are now well positioned to understand and address health disparities at the global, national, and local levels. The global resurgence of interest in addressing health disparities in the 1990s and 2000s through various movements, such as the WHO Commission on the Social Determinants of Health and their final report with evidence-based recommendations,^{4,5} have provided momentum to countries around the world to re-engage in dialogue at the national and international levels for this vitally important issue. As part of this global resurgence, a Canadian commission on health equity has been established with a mandate to support policy change for the determinants of health nationally and locally.^{5,6} Although much has been said about population health being everybody's business, the importance of the role of government, from national to local, cannot be overstated. Canadian governments can organise the balance between local specificity and national coherence needed for effective and lasting reductions in health disparities through action on social determinants of health, synchronising disparate elements of our multinational, multicultural, and federal character. Thus, we propose five recommendations for action to elucidate and address health disparities. First, a national population health framework to set the stage and lead the way. Second, a coordinated and integrated population health-information infrastructure that includes culturally appropriate, community-relevant indicators. Third, a plan to assess population health initiatives and relay the information to policy makers. Fourth, a life-course perspective on health disparity issues and setting priorities. Last, education, research, training, and professional opportunities that build capacity for innovation and implementation of the interdisciplinary, interprofessional, and multijurisdictional strategies for societal action on the determinants of health.

Despite a long history of efforts to incorporate population-health reforms, goals, and targets into the Canadian setting, not only have we been unsuccessful in reducing health disparities, but also we have seen them increase.⁷ This lack of success is a serious concern not only for the people affected but also for economic and social development of the country as a whole. In light of these circumstances, a national framework for population health is crucial to lead the way. Although framework

documents cannot guarantee success in reduction of disparities, they can stimulate action by focusing public and political attention on the issues, and thereby become a benchmark by which governments can be held to account. For example, the Royal Commission on Health Services (1961–65) provided a blueprint for public medical-care insurance in Canada.⁸ Internationally, the Beveridge⁹ report in the UK provided a model for the development of a post-war welfare state that resonated across western states in the same way that Canada's Lalonde report¹⁰ later inspired new ways of talking about the factors that make people healthy both in Canada and abroad. The UK has adopted a unique, whole-of-government approach to improve population health¹¹ and has set specific targets to reduce health disparities. Sweden's public-health legislation includes health objectives and measurable targets for 50 government departments and agencies, and requires these departments to assess the health effects of any proposed new law and regulation.¹² In Europe, the Verona Benchmark¹³ provides a set of system characteristics for countries and regions that is important for the development, implementation, and improvement of the health of populations through investments in health.

A national population health framework that is responsive to evolving knowledge on social determinants of health, and which integrates considerations for structure, process, and funding, holds promise for achievement of goals for reduction of health disparities. The national framework needs to explicitly include linkages with jurisdictions, sectors, and stakeholders. Short-term and long-term goals, objectives, and targets are important for the framework to have the greatest chance of influence in the reduction of health disparities. Similar opinions have been conveyed by the Organisation for Economic Co-operation and Development's project on population health investment policies.¹⁴ Indeed, the Public Health Agency of Canada's previous work on setting public-health goals for the nation are restricted to aspirational statements, without the specific goals and targets that are needed to set the stage for policy action by governments, especially since government mandates are short term compared with long-term policy effects on the social determinants of health. Identification of intermediate and process targets that meet short-term mandates can maintain momentum towards long-term goals.

Canada is fortunate to have excellent data sources and infrastructure to record and track health status and health inequalities.^{15–17} Other developed countries, such as

Australia, the UK, Finland, New Zealand, Norway, and Sweden, and the international organisations, such as WHO, have established national and international surveys (eg, World Health Survey) to monitor health indicators.^{7,18} Although data and information from these surveys are powerful methods by which to understand and address health disparities, these surveys only assess traditional quantitative indicators, such as life expectancy, mortality, morbidity, and perceived health status.¹⁹ Other indicators relevant to various communities and their unique needs, geographies, and histories should be included in these surveys. The Saskatchewan Population Health and Evaluation Research Unit has been a leader in the development of culturally appropriate, locally relevant frameworks and indicators, working on one project with several Aboriginal and northern communities²⁰ and on another with provincial government to evaluate population-level interventions to promote child health.²¹ In these projects we noted that in addition to the development and use of quantitative measures of population health, qualitative research and evidence can add depth and nuances necessary for fully understanding and to address health disparities, in essence following Lalonde who challenges us to identify factors and consider how they may be measured.²²

Despite excellent data sources, we do not have reliable and timely data for the health needs and outcomes of ethnocultural and geographically distinct (ie, rural and remote) groups. National and international population surveys, such as the Canadian Community Health Survey²³ and the World Health Survey¹⁸ do not include individuals living in institutional settings—eg, elderly people living in long-term care facilities, even though Canadian statistics show a continued increase in the proportion of people older than 65 years from 5% in 1921 to 20% by 2026. Information about some populations is absent or of poor quality (notably for Canada's Aboriginal population, which has some of the worst health outcomes in Canada, and for ethnic and cultural minorities such as new immigrants). The sampling frameworks used in the Canadian national surveys hinder accurate estimates of health events in various small communities in rural and remote areas that represent about 30% of the Canadian population. Community-level breakdown of data for the health needs, disparities, and outcomes is essential. A relevant example is indigenous communities, in which the capacity to define, gather, analyse, and respond to health information is seen as an important step towards community empowerment and self-determination. The same could be said for the relevance of community-level data to other stakeholders in Canada and indeed globally.²⁴

The federal government can provide leadership in the improvement of data availability through the development, implementation, and evaluation of a nationally coordinated and integrated population-health information infrastructure that is responsive to community and

national needs by building on existing data and information repositories and networks, such as in the Manitoba Centre for Health Policy.²⁵ Individuals and groups working to address health inequalities need access to these integrated information sources, which are invaluable for grassroots and organisational networking, health planning, and evidence-based interventions. The unique data links made possible by the Manitoba Centre coupled with its research connections to local organisations, create a proven capacity to move beyond descriptions of population health status to connect health data with the programmes and policies that might contribute to good outcomes.²⁵

Although we have begun to describe the extent of health inequities,^{16,17} further assessment and research are needed to explain and predict the complex interaction of various health determinants so that we can intervene appropriately to reduce disparities in the social determinants of health. Canadian examples can be found in Aboriginal communities and organisations in which investments have been made in cultural determinants of health,²⁶ or in cross-jurisdictional and intersectoral partnerships in the creation of an integrated community model of primary health-care delivery.²⁷ Indicators used in the assessment of the various phases of research, and programme and policy initiatives need to be culturally appropriate, relevant to the community, and developed collaboratively.^{20,21} Effective evaluations are part of any programme and policy initiative from the planning stages²⁸ so evaluation should be integrated into the development and implementation of the national population health framework with dedicated time and resources. Internationally, countries such as Australia, Finland, Norway, and Sweden have established national research programmes for health disparities to advance population health.⁷ The federal government in Canada can provide leadership in advancing research and assessment, and creating new knowledge by building on the efforts of other countries.²⁹ Similarly, we urge provincial, regional, and local governments to take evaluation more seriously than they have to date, making it a key component of any population health initiative.

Reduction of health disparities requires collaboration between researchers, communities, policy makers, and practitioners, and requires a life-course perspective. We know, for example, that poverty is an important determinant of health; studies have drawn attention to the transitions of populations in and out of poverty during the course of their lives, and even between generations.³⁰ A goal of substantial poverty reduction is, however, feasible. In a Saskatchewan study, the proportion of the provincial gross domestic product needed to bring all the poor in the province up to the poverty line was only 1·4%.³¹ Even though wealth transfer in this context is controversial, this type of approach could certainly be argued to be consistent with Canada's international commitment³² to the UN Millennium Development Goals (several of

which, such as poverty reduction, universal primary education, sexual equality and empowerment, encompass the social determinants of health), and similar strategies at home and more locally could be argued to be equally relevant for consideration. Because of the transitional nature of poverty during the course of life, use of economic and other population-health means to address inequities is important. Another example of the importance of life-course perspective relates to early childhood development, which has implications for adult life. As such, a life-course perspective necessitates researchers, policy makers, and stakeholders to invest in understanding health inequalities in the various phases of life.

Health disparities are affected by numerous determinants in many sectors and at many levels, yet we continue to identify problems and develop solutions in isolation that is maintained and reinforced by structural, professional, and resource boundaries. Professional development and continuing education opportunities have already proven invaluable for the understanding and application of population health frameworks in the health-planning process, identification of community-health needs, and addressing health inequalities.³³ The need for innovative postgraduate education and professional training initiatives with an interdisciplinary approach to health research, policy, and practice (including the societal and cultural dimensions of healthy populations) has been recognised, implemented, and assessed.³³ Education and training programmes that create new health knowledge and apply research findings through partnerships with community-based organisations, policy makers, advocates, lobbyists, and different levels of government can improve the quality of the questions we ask about health disparities, innovate approaches to finding the answers, and ultimately translate them into action. This approach has great promise within the international development context, especially in the achievement of the Millennium Development Goals, supporting capacity development, ensuring sustainability of education and training opportunities, and contributing to a better global future for all.³⁴

To conclude, progress in the reduction of health inequalities can follow from national actions such as those suggested here along with recommendations for action arising from the WHO Commission on the Social Determinants of Health. We know that the social determinants of health are not restricted by political, geographical, or jurisdictional boundaries. Coordination, collaboration, and dialogue across these boundaries, with mediation through a framework that captures the imagination and energies of all levels and stakeholders could lead to bold responses, like Canadian Medicare in the 1960s. This type of approach is needed if we are to make genuine progress towards reduction of health disparities through action on the social determinants of health.

Conflict of interest statement

We declare that we have no conflict of interest.

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