

## PERSPECTIVES

# Beyond policy analysis: the raw politics behind opposition to healthy public policy<sup>†</sup>

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### SUMMARY

*Despite evidence that public policy that equitably distributes the prerequisites/social determinants of health (PrH/SDH) is a worthy goal, progress in achieving such healthy public policy (HPP) has been uneven. This has especially been the case in nations where the business sector dominates the making of public policy. In response, various models of the policy process have been developed to create what Kickbusch calls a health political science to correct this situation. In this article I examine an aspect of health political science that is frequently neglected: the raw politics of power and influence.*

*Using Canada as an example, I argue that aspects of HPP related to the distribution of key PrH/SDH are embedded within issues of power, influence, and competing interests such that key sectors of society oppose and are successful in blocking such HPP. By identifying these opponents and understanding why and how they block HPP, these barriers can be surmounted. These efforts to identify opponents of HPP that provide an equitable distribution of the PrH/SDH will be especially necessary where a nation's political economy is dominated by the business and corporate sector.*

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### INTRODUCTION

The arguments for developing and implementing healthy public policy (HPP) that strengthens and equitably distributes the prerequisites/social determinants of health (PrH/SDH) are long-standing and appear—at least to many health promoters—to be persuasive (Milio, 1986; World Health Organization, 1986, 2008a; Leppo *et al.*, 2013). Nevertheless, it has been long been noted that these concepts are contested with implementation anything but assured (Milio, 1986; Graham, 2004; Robert Wood Johnson Foundation, 2010). In response, it has been argued that attention be directed to the public policy processes that would facilitate its implementation (Clavier and de Leeuw, 2013b). Kickbusch calls this new field of study *health political science* (Kickbusch, 2013).

There are many aspects of a health political science. These include analysis of policy content, policy processes, policy actors and the politics behind decision-making by authorities (Clavier and de Leeuw, 2013a). One useful way of illustrating these different aspects is Kingdon's model of agenda setting (Kingdon, 1984). Kingdon argues that for an issue to make it onto the public policy agenda three streams need to align to create a policy window: problems, proposals and politics. The problems stream is about policymakers recognizing the importance of an issue; the proposals stream involves the process of developing possible solutions and the politics stream is about the ideologies and belief systems of ruling authorities and the ability of advocacy and opposition groups to have their views acknowledged (de Leeuw *et al.*, 2013). Concerning the importance and problematic

aspects of the last stream, [Milio \(1986\)](#) long ago noted:

These choices (policy decisions) are political decisions. The answers come most often from those who are organized to protect their interests, not necessarily from all segments of the population who will be affected by the policies (p. 84).

Efforts have been made to apply these and other insights from the public policy literature to health promotion and HPP issues ([Signal, 1998](#); [Bryant, 2002](#); [Bambra et al., 2005](#)). It has been noted that many of these applications consider the public policy making process to be a rational ideas-driven process with less analysis of the underlying politics that drive public policymaking. As [Bambra et al. \(Bambra et al., 2005\)](#) state:

It is profoundly paradoxical that, in a period when the importance of public policy as a determinant of health is routinely acknowledged, there remains a continuing absence of mainstream debate about the ways in which the politics, power and ideology, which underpin it influences people's health (p. 187).

The neglect of politics, power and ideology in the HPP literature should not be surprising as much of the HPP literature has been concerned with specific health issues such as tobacco and alcohol use, diet and physical activity, environmental concerns about pesticides use and exposure to toxins, spatial issues of neighbourhood organization and healthcare related to access and coverage rather than the distribution of the PrH/SDH ([Milio, 1986](#); [Luginaah et al., 2001](#); [Stuckler and Siegel, 2011](#); [Lazar et al., 2013](#); [McQueen, 2013](#)). These former issues certainly involve aspects of politics, power and ideology, especially in relation to interests that profit from the distribution of tobacco and junk food, lack of government regulation of industry and development, and favoured status of the health care industry over the public health sector ([Milio, 1986](#); [de Leeuw, 1989](#)). [de Leeuw](#) argues that many of these issues can transcend left-right political commitments ([de Leeuw, 2013](#)).

But there are other more contentious areas where the *raw politics* ([Clavier and de Leeuw, 2013a](#)) of power and influence may play a greater role: PrH/SDH issues of income and wealth distribution, tax structures, provision of shelter and food security, employment and working conditions, the availability of health and social services and the ability of individuals and communities to control these PrH/SDH. It is in these areas that deal with

control and distribution of economic resources where we can expect that competing societal interests would be more likely to manifest opposition to HPP that equitably distributes the PrH/SDH.

In addition, the resurgence of neo-liberal ideology in the past three decades—an ideology that believes that governments should withdraw from managing the economy thereby ceding more power and influence to the business and corporate sector is also affecting the distribution of the PrH/SDH ([Coburn, 2001, 2004](#); [Harvey, 2007](#); [Navarro, 2007](#)). Yet, it is uncommon to see explicit examination of how this ideology is shaping the quality and distribution of the PrH/SDH and what would be the forces supporting such ideology ([Bryant, 2013](#)).

Another reason for the neglect of the raw politics of power and influence in HPP is that providing an equitable distribution of PrH/SDH is less contentious in many nations where it is supported across the political spectrum. Many Western European nations have made efforts to assure that citizens are provided with the PrH/SDH necessary for health ([Raphael, 2013a, b](#)). This however may be less the case in nations identified as Liberal welfare states such as Australia, Canada, New Zealand, the UK and USA ([Navarro and Shi, 2001](#)). Political economists use the term Liberal to refer to the form of capitalism that emerged in England during the late 18th century ([Esping-Andersen, 1990](#)). It is an approach that favours the unimpeded operation of the capitalist economic system and reifies individual initiative at the expense of government intervention into the operation of the economic system.

It is in these Liberal countries where opposition to the equitable distribution of PrH/SDH may be organized to resist these forms of HPP. And it is in these nations that the promise and hope of rational ideas-driven HPP approaches to the PrH/SDH continues to be pursued ([Public Health Agency of Canada and Health Systems Knowledge Network, 2007](#); [Health Council of Canada, 2010](#)).

But it is not only the Liberal welfare states that see opposition to the equitable distribution of the PrH/SDH. All developed nations have been subject to welfare state retrenchment that can skew the distribution of the PrH/SDH ([Eikemo and Bambra, 2008](#)). Even welfare state powerhouse Sweden is beginning to resemble the problematic Liberal welfare state profile ([Raphael, 2014](#)). Why is this and what are the implications for developing HPP that assures the equitable distribution of the PrH/SDH?

The social inequality and political economy literatures provide insights into how powerful interests can shape the making of public policy to skew the distribution of PrH/SDH among differing social classes, genders and races, among other social identities (Grabb, 2007; Coburn, 2010). These literatures not only identify potential barriers to HPP, but also provide means of overcoming these barriers.

In this article, I explore the value of identifying the specific sector of society—the business and corporate sector—which opposes HPP that provides an equitable distribution of the PrH/SDH. I do not deny the importance of careful application of public policy theories and analyses to determining means of promoting the PrH/SDH-related HPP agenda. But I move beyond policy analysis to consider how focus on the raw politics of power and influence can identify and confront these problematic sectors.

The approach I take also calls for a critical analysis of the concept of intersectoral cooperation in building of HPP. The intersectoral approach employs a consensus model of society which may not be appropriate in cases where there is sectoral opposition to HPP that equitably distributes the PrH/SDH (Bryant, 2009). Finally, the focus here is on wealthy developed nations with special emphasis on the Canadian scene, but the analysis can be extended to low- and middle-income nations. Concern with the influence of raw politics on HPP will especially be the case where a nation's political economy is dominated by the business and corporate sector. The Appendix provides an historical context for such an analysis.

### **HEALTHY PUBLIC POLICY IS ABOUT POWER, INFLUENCE AND RESOURCE ALLOCATION**

Health promotion is the process of enabling people to increase control over, and to improve, their health (World Health Organization, 2013). It is recognized that much of this involves access to the PrH/SDH of income, food, shelter, employment and working conditions, and health and social services through implementation of HPP (World Health Organization, 1986, 2008b). Four key statements—among others—exemplify the World Health Organization's emphasis upon developing HPP that provides an equitable distribution of PrH/SDH: the Ottawa Charter,

Adelaide Recommendations, Belfast Declaration, and Helsinki Statement on Health in All Policies.

### **The importance of healthy public policy**

The Ottawa Charter on Health Promotion outlined how the basic prerequisites of health—or social determinants in modern usage—of peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity are shaped by public policy: *Health promotion policy combines diverse but complementary approaches including legislation, fiscal measures, taxation and organizational change*. HPP is public policy that supports rather than threatens health.

The Adelaide Recommendations on Healthy Public Policy emphasized the importance of HPP and how it should be characterized by an explicit concern—and accountability for—health and equity in all areas (World Health Organization, 1988). Public policy should create supportive environments that enable people to lead healthy lives: Health for All will be achieved only if the creation and preservation of healthy living and working conditions become a central concern in all public policy decisions.

The Belfast Declaration on Healthy Cities called for an explicit concern with reducing inequalities and addressing poverty through local action (World Health Organization, 2003). It saw cities as prime sites for such activity such that good city planning and strategic partnerships for health would promote governance that assured that citizens have a key role in developing health promoting city policies and plans.

The Helsinki Declaration on Health in All Policies reaffirmed the importance of public policy action to support health: *Health in All Policies is an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies and avoids harmful health impacts in order to improve population health and health equity...* It includes an emphasis on the consequences of public policies on health systems, determinants of health and well-being (World Health Organisation, 2013). (The term Health in All Policies appears to have superseded the use of Healthy Public Policy. It assumes that governments are interested in applying it in their policymaking, a point I am not convinced of in many cases.)

Despite these—and other—WHO declarations and charters on the importance of HPP and the PrH/SDH (World Health Organization, 2009), there is little literature on why these

principles have been taken to heart by policy-makers in some nations but not others (Raphael, 2013b). Rather than seeing these differences as reflecting the presence or lack of evidence (every nation's policymakers have access to this information), or organizational capacity of governments and advocacy groups, they may be due to national differences in the power and influence of societal sectors to shape public policy.

The social inequality and political economy literatures provide signposts of how the assertion of power and influence by particular sectors acts through economic and political systems to shape the making of public policy that distributes the PrH/SDH. Various ways of describing these different groups whose interests conflict in a society exist: classes, occupations, elites etc. I use the term sectors as it is used in the political economy literature to differentiate between the interests of business, organized labour and civil society, where the State mediates these interests. Such insights may help explain why so few HPP initiatives that address the PrH/SDH have been implemented in Canada, as one example (Low and Therault, 2008; Hancock, 2011).

### The role of power and influence in resource allocation

The idea that power shapes resource allocation that can affect health is not new. As early as 1845 Friedrich Engels argued the owners and managers of the economic system created the profound material and social deprivation that led to early mortality among the working class in England (Engels, 1845/1987). During the same period Rudolph Virchow pointed to the lack of democratic institutions as driving the typhus epidemic in Upper Silesia, a Polish province of Prussia (Virchow, 1848/1985). And more recently, the World Health Organization's Commission on Social Determinants of Health stated that the inequitable distribution of health enhancing and damaging experiences was the result of 'poor social policies and programmes, unfair economic arrangements, and bad politics' (World Health Organization, 2008a).

A basic tenet of the *social inequality* literature is that power and influence varies among those of different classes, statuses and parties or associations (Grabb, 2007). Karl Marx and Friedrich Engels identified social class as a key indicator of the power to shape the distribution of income and wealth (Marx and Engels, 1848). Max Weber

recognized the importance of social class and added status factors of occupation, gender and religion as indicators of the power to access societal resources (Weber, 1922/2013). Parties were professional associations that also gained power and influence. For Weber—as well as Marx and Engels—the politics of everyday life was essentially a struggle among individuals for power and influence.

Class determines one's power and influence in the economic sphere of life. The owners and managers of business can shape the operation of the political and economic systems. Wright argues that the rather strong term 'oppression' can be applied when those who control the economic system extract resources for themselves to such an extent that others suffer material deprivation and this relation is coercively enforced through legislation (Wright, 1994). Status and party also affords power and influence through the social-honour or prestige spheres of life and can lead to skewing of the distribution of PrH/SDH. All these kinds of power create varying access to material resources resulting in differing life chances—including health (Kitchen, 2005).

The *political economy* literature extends these insights by considering how the power and influence of these classes, occupations and parties act through political and economic systems to distribute resources (Bryant, 2009; Coburn, 2010). Both literatures are concerned with *Who gets what, how, and why?*; a phrase denoting the essence of *politics* in a society (Lasswell, 1936/2011). Since the ability to control the PrH/SDH is shaped by the ability to influence society through the operation of the economic and political systems, a neglect of the role of power and influence in the HPP literature related to the PrH/SDH is problematic (Bambra *et al.*, 2005; Raphael and Bryant, 2006).

Which societal sector might oppose equitable distribution of the PrH/SDH? These literatures would suggest the owners and managers of business with the support of citizens who come to agree with these views would be these villains. This citizen support may be misguided ('false consciousness') whereby individuals come to hold the very beliefs and attitudes that work against their own self-interest (Wilson, 1983), one example being people living in poverty supporting the public policies that create their adverse living conditions.

The power and influence of owners and managers is channelled through control of the

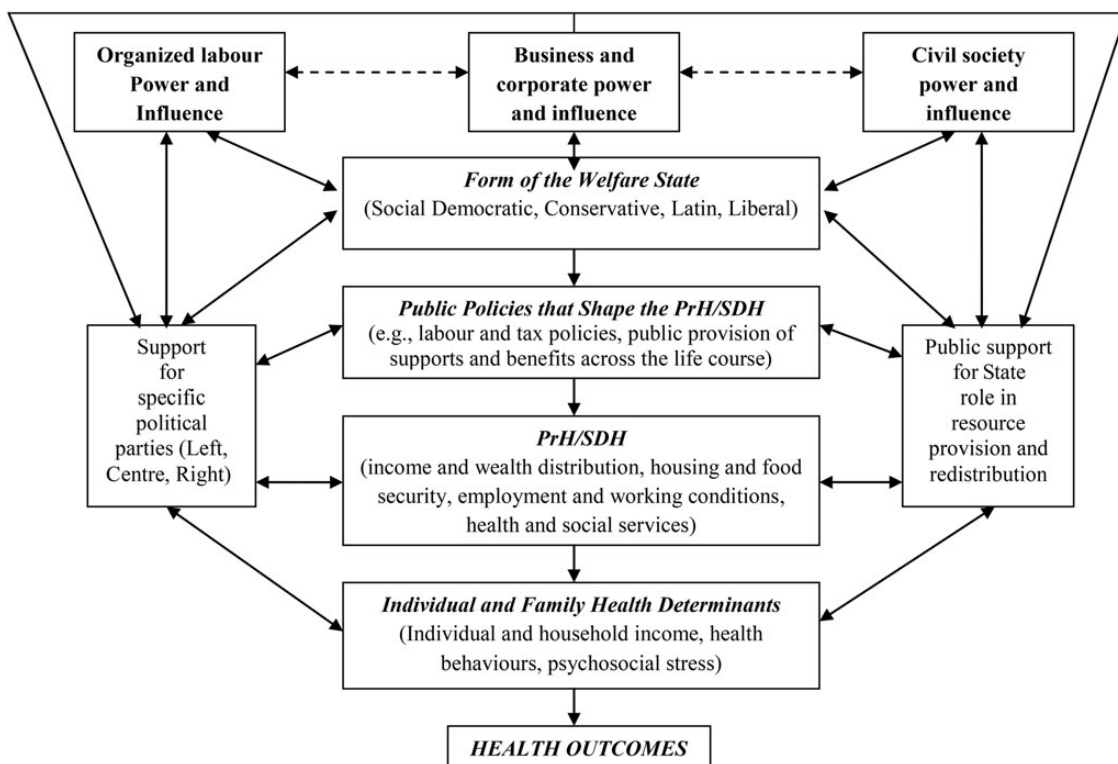
economic and political systems which creates public policy that skews the distribution of the PrH/SDH. As will be discussed, the ability of these differing sectors to shape public policy—and the resultant distribution of the PrH/SDH—depends upon their relative power and influence in relation to the labour movement and civil society. The following sections depict how these effects manifest through a range of political activities. Figure 1 provides a model of these processes.

At the top of Figure 1, there are the three key sectors that influence the entire public policy process. The *Business and Corporate Sector* is centrally placed as it has the greatest potential in capitalist societies—and all wealthy developed nations are capitalist—to shape aspects of economic and political systems, public policy making and the quality, and distribution of the PrH/SDH. It also has the ability to shape the attitudes and values of the public through its creation of ideological discourse—the ways society members come to think about these issues (Grabb, 2007).

## POLITICS AND THE DISTRIBUTION OF THE PRH/SDH

A fundamental goal of HPP should be assuring that PrH/SDH are equitably distributed such that no one experiences material and social deprivation that threatens health (Labonte, 1986; World Health Organization, 1986). The importance of the *distribution* of the PrH/SDH is seen in Hillary Graham's distinction between the PrH/SDH proper and their distribution (Graham, 2004). The former points out their general importance while the latter inquiries into how equitable or inequitable distributions come about. Analysing public policy is key to such understandings and begs the question: why does public policy distribute PrH/SDH more equitably—with resultant differences in extent of health inequalities—in some jurisdictions and not others? (Bambra, 2012; Raphael, 2013a, b).

The answer is in the *politics* of these jurisdictions. For Bambra *et al.*, politics influences health and the distribution of PrH/SDH through four



**Fig. 1:** Depiction of Pathways by which the Relative Strengths of the Business, Labour, and Civil Society Sectors act in concert with Form of the Welfare State and Voter Political Activity and Public Opinion to produce Public Policy that shapes the Quality and Distribution of the PrH/SDH (Adapted from Raphael, 2014).

somewhat interrelated aspects: *Politics as Power, Politics as Government, Politics as Public Life, and Politics as Conflict Resolution* (Bambra *et al.*, 2005). All are interrelated such that when the power of differing sectors is balanced within a society, quality of the other aspects of politics is enhanced.

### Politics as power

Politics is the process through which desired outcomes are achieved in the production, distribution and use of resources in all areas of social life (Bambra *et al.*, 2005). In wealthy developed countries—all of which are capitalist economies—sectors whose interests compete are business, labour and civil society. The State acts as mediator of these interests (Bryant, 2009).

The business and corporate sector has power and influence through its control of the economic and political systems (Bryant, 2009). It possesses various levers of power—primarily its ability to move and invest capital—that shape how governments develop and implement public policies that distribute the PrH/SDH. In regard to this distribution, the business sector usually favours less provision of social and economic security and advocates for weakened government management of employment practices, and fewer support programmes and benefits, all of which results in less redistribution of income and wealth (Leys, 2001; Macarov, 2003; Langille, 2009). Its call for lower taxes—especially for the corporate sector and the wealthy—weakens governmental ability to provide benefits and supports that provide economic and social security to the population (Menahem, 2010). Indeed, Scambler asks whether workers' illness can be a side-effect of excessive profit-making by capitalists (Scambler, 2009).

The organized labour sector usually supports greater redistribution through higher taxation on the business and corporate sector and the wealthy, stronger government management of the workplace and greater provision of supports and benefits (Navarro *et al.*, 2004). It gains power and influence through the percentage of the population that belong to trade unions and its alliance with governing parties of the left (Brady, 2009; Bryant, 2009; Navarro and Shi, 2001). The civil society sector gains power and influence from its ability to influence public opinion and shape public policy through networks of agencies, organizations and other non-governmental institutions (Brady, 2009). And of course, the

citizenry itself has influence through its ability to elect representatives to governments.

The balance of power among sectors differs among nations with resulting impacts on the distribution of the PrH/SDH (Raphael, 2013b). It has long been noted that public policy approaches of the Nordic nations of Denmark, Finland, Norway and Sweden act such that the distribution of PrH/SDH is more equitable than in the Anglo-Saxon nations of Australia, Canada, New Zealand, UK and USA (Navarro and Shi, 2002; Innocenti Research Centre, 2005; Health Council of Canada, 2010). [Denmark provides a conundrum for a welfare state analysis in that its life expectancy is very low in comparison with other wealthy developed nations. Its infant mortality rate, however, is very favourable and there is evidence that it has begun to explicitly address issues of health equity in its public policy (Povlsen *et al.*, 2014)].

The nations of Continental Europe such as Belgium, France, Germany and the Netherlands fall midway between the Nordic and Anglo-Saxon nations. In both the Nordic and Continental nations consultation and communication among these sectors is common, sometimes institutionalized and sometimes informal (Swank, 2002). This is usually not the case in the Anglo-Saxon nations, a situation that is sometimes called 'disorganized capitalism' (Offe, 1985).

For Esping-Andersen, variations in power and influence are related to qualitatively different welfare state regimes that overlap with the Nordic, Anglo-Saxon and Continental categories (Esping-Andersen, 1990, 1999). Social Democratic welfare states—the Nordic nations—are distinguished by their strong commitments to State provision of citizen economic and social security—a concept that appears closely related to provision of the PrH/SDH. The Liberal welfare states—the Anglo-Saxon nations—generally rely upon the economic marketplace to distribute economic and social resources. (There is some variation among Liberal welfare states with Australia, Canada, New Zealand and UK providing universal healthcare and somewhat more inclusive welfare systems than the USA, but these nations have distinctive common characteristics consistent with their Liberal designation.) The Conservative welfare states—the Continental nations—are distinguished by their emphasis upon social insurance programmes that reduce economic and social risks among wage earners. The Latin welfare state is a less developed form of the Conservative

welfare state (Spain, Portugal, Italy and Greece) (Saint-Arnaud and Bernard, 2003). In both the Social Democratic and Conservative—and to some extent the Latin—welfare states there is significant coordination of employment and wage structures across economic sectors and among unions (Pontusson, 2005; Swank, 2005). These serve to provide higher proportions of the labour force working under collective agreements than the Liberal welfare state nations (Organisation for Economic Co-operation and Development, 2013). This both limits the power and influence of the business and corporate sector and makes the implementation of equitable PrH/SDH-related HPP more likely.

In terms of the issue of power and influence and the ability of specific societal sectors to support or oppose the making of PrH/SDH-related HPP, in the Social Democratic regime organized labour has come to have significant influence—by virtue of its strong membership and alliances with governing parties of the left—in the making of public policy (Einhorn and Logue, 2003). The primary ideological inspiration of this regime is Equality that is implemented through public policies made by its dominant institution, the *State* (Saint-Arnaud and Bernard, 2003). In contrast, the Liberal welfare regime's primary ideological inspiration is Liberty as manifested through its primary institution, the *Marketplace*. Here public policy is shaped in the interest of business and the efficient—and profitable for business—operation of the economic system. Such policy can also lead to suppression of unions by making organizing more difficult. Here, the organized labour movement tends to be weak, and in many instances civil society organizations have less influence upon the public policy process (Raphael, 2012c).

Not surprisingly, the Social Democratic regime's quality and distribution of the PrH/SDH are clearly superior to what is seen in the Liberal welfare regime (Raphael, 2013b). The third welfare regime, the Conservative—and the undeveloped Latin—has the Family as its dominant institution, supported by social insurance programmes—usually forged by cooperation of the State and the Marketplace that provide economic and social security (Saint-Arnaud and Bernard, 2003). Its primary ideological inspiration is Solidarity. It maintains status differences and the quality and distribution of the PrH/SDH under this welfare regime falls midway between the Social Democratic and Liberal (Raphael, 2013b). This analysis suggests that the ability of the

business sector to block HPP that distributes the PrH/SDH would be stronger under the Liberal welfare state regime and closely associated with *politics as government*.

### Politics as government

Politics as government is concerned with the art of government and activities of the State (Bambra et al., 2005). Government is responsible for the making of public policy that influences the distribution of the PrH/SDH. Its most obvious manifestation is its providing citizens with economic and social security through a wide range of public policy areas such as education and training, family, labour, shelter, taxation, and health and social services among others (Raphael, 2012c). And not surprisingly, this aspect is linked to the welfare regime typology described earlier (Raphael, 2013b).

The Social Democratic welfare states of Finland, Norway and Sweden have become HPP leaders through proactive approaches towards public policy that provides quality and equitable distribution of the PrH/SDH (Backhans and Burstrom, 2012; Fosse, 2012; Mikkonen, 2012). This is in contrast to Liberal welfare states—typified by Australia, Canada, New Zealand, UK and USA—where modest supports and programmes are targeted and subject to means-testing (Raphael, 2013a, b). The Conservative and Latin welfare states' social insurance programmes provide citizens with economic and social security midway between these welfare regimes.

The most obvious manifestation of these politics as government differences is the amount of public and social spending expenditures for citizens across the life span. Social Democratic and Conservative—and to a lesser extent Latin—nations are more generous and encompassing in citizen support—child benefits, employment training and support, public pensions—than Liberal nations (Pontusson, 2005; Olsen, 2010). Not surprisingly, poverty rates and extent of income inequalities parallel these spending differences (Raphael, 2013b).

Electoral politics and political history explain much of the variation among these nations' willingness to develop HPP that address the PrH/SDH. Social Democratic nations have seen more widespread governance by social democratic parties of the left that maintain a healthy skepticism towards the capitalist economic system (Esping-Andersen, 1985; Rainwater and Smeeding, 2003; Brady, 2009). Their universalist

and generous benefits and programmes secured the loyalties of the middle and working classes for a State role in resource provision and redistribution (see Figure 1) (Esping-Andersen, 1990, 1999). The Liberal welfare state has little of this skepticism and embraces free market ideology, one result of which is the inequitable distribution of the PrH/SDH (Raphael, 2013a, b). The Conservative welfare state is also sceptical of unbridled capitalism and has been historically influenced by the Church (Esping-Andersen, 1990, 1999). Here, the business and corporate sector is more likely to recognize the benefit of the status quo and promote social and economic solidarity (Saint-Arnaud and Bernard, 2003). The result of all this is a wide range of differences in public policies, the dominant difference emerging between the ‘social economies’ of Europe and the Liberal welfare state regime associated with the Anglo-Saxon heritage (Pontusson, 2005).

### Politics as public life and as conflict resolution

The third and fourth forms of politics are about daily life and the expression and resolution of conflicts through compromise, conciliation, negotiation and other strategies (Bambra *et al.*, 2005). One way of thinking about politics as public life is the amount of citizen involvement—and therefore power and influence—through civil society organizations. Interestingly, such involvement appears to be much higher in Social Democratic welfare states than under the Liberal welfare regime (Saint-Arnaud and Bernard, 2003; Wijkström, 2004). In contrast to the common sense view that in a well-developed welfare state that takes care of its citizens through benefits and programmes, citizen involvement would be less, it is actually greater (Rostila, 2013). Citizen involvement is a key tenet of the Healthy Cities Movement (World Health Organization, 2003). Not surprisingly, there is evidence that PrH/SDH-related HPP is more likely when such participation is higher (Saint-Arnaud and Bernard, 2003; Raphael, 2012c).

In terms of politics as conflict resolution, we see greater citizen involvement in the day-to-day affairs of municipal governments in the Social Democratic welfare regime than elsewhere (Schraad-Tischler, 2011). Cynicism towards government and belief that governments are corrupt are lower in Social Democratic welfare states (Saint-Arnaud and Bernard, 2003; Schraad-Tischler, 2011). Governments that provide social justice stimulate citizen involvement in the

day-to-day affairs of governance, activities of local institutions and agencies (Rostila, 2013; Wijkström, 2004).

The implications of this analysis are that differing forms of the welfare state will have differing power balances and imbalances. In the Liberal welfare state the forces that favour the provision of quality and equitable distributions of the PrH/SDH through the making of HPP will generally be at a disadvantage. Arguments for HPP may not be as persuasive since they will run afoul of those societal sectors with more influence with policymakers. The result is the blocking of public policies that will enhance the equitable distribution of the PrH/SDH. While form of the welfare state will provide differing receptivity to these issues, they in themselves will not completely determine governmental action. Other aspects in Figure 1 play a role.

### ECONOMIC GLOBALIZATION AND THE PRH/SDH: CANADA CASE STUDY

Economic globalization provides an illustration of how power and influence, politics and form of the welfare state comes together to influence public policy that shapes the distribution of the PrH/SDH. Labonte and Schrecker and Friel *et al.* have provided especially useful insights into how economic globalization and associated trade agreements are shaping the making of HPP and the ability of governments to equitably distribute the PrH/SDH (Labonte and Schrecker, 2007a, b, c; Friel *et al.*, 2013). These effects are noticeable across developed and developing nations and it is probably in the latter case where the effects of power and influence upon the distribution of PrH/SDH are particularly stark (Kim *et al.*, 2000; Labonté *et al.*, 2009).

It is frequently argued that increasing economic globalization requires that national jurisdictions compete in a ‘race to the bottom’ by which employment standards are weakened, wages lowered and government revenue collection and social programmes reduced in order to compete in the international marketplace (Swank, 2005; Teeple and McBride, 2010). National jurisdictions, it is said, have no choice but to succumb to these economic pressures with a resulting deterioration in the distribution of the PrH/SDH. Not surprisingly, this argument is usually supported by the business sector (Leys, 2001; Langille, 2009).



However research evidence indicates that national responses to the imperatives of economic globalization are primarily determined by the internal politics of the nation (Swank, 2002; Coburn, 2004; Banting and Myles, 2013). The Social Democratic and the Conservative welfare states—it is unclear where the Latin states fall—have been more able to resist these pressures than Liberal welfare states. Much of this is attributed to differences in the power and influence of societal sectors, ideology of ruling parties as well as the general tendency for nations to continue on their accustomed public policy trajectories, a process political economists call path dependency (Swank, 2002). The policy process in Liberal welfare states, already dominated by the business and corporate sector, has fewer means of resisting pressures for welfare state retrenchment that makes the distribution of PrH/SDH less equitable (Eikemo and Bambra, 2008). An illustration of this can be seen in the case of Canada, where recent events have weakened an already undeveloped welfare state (Bryant *et al.*, 2011).

Canada has been a leader in developing health promotion concepts and there is no shortage of researchers identifying the importance of HPP that would equitably distribute PrH/SDH or advocates for its implementation. Indeed, Public Health Agency of Canada documents (Public Health Agency of Canada, 2007), Canadian Senate reports (Senate Subcommittee on Population Health, 2008a, b) and arms-length federally funded agencies such as the Canadian Institute for Health Information (Canadian Institute for Health Information, 2002) and the Health Council of Canada (Health Council of Canada, 2010) call for a HPP approach that equitably distributes the PrH/SDH.

But Canada has been a laggard in implementing HPP (Collins and Hayes, 2007; Bryant *et al.*, 2011; Hancock, 2011). This is especially the case regarding HPP that shapes the distribution of the PrH/SDH as Canada presents one of the worse profiles among wealthy developed nations with indications that the profile is further decaying (Bryant *et al.*, 2011; Raphael, 2013b). Indeed, issues of PrH/SDH are not on the public policy agenda at any governmental level in Canada. In this, Canada is similar to the situation in the USA (Bezruchka, 2012).

In terms of the model provided in Figure 1, Canada, being a Liberal welfare state has historically neglected making public policy that equitably distributes the PrH/SDH. Worse, the Canadian

business and corporate sector since the 1980s has come to dominate the public policymaking process with resultant declines in the quality and equitable distribution of the PrH/SDH (Scarth, 2004; Healy, 2008; Langille, 2009; Raphael, 2009b). Evidence is available that the processes contributing to these declines in Canada include growing corporate concentration, declines in union density and the skewing of income and wealth among the top 1% of Canadians (Brennan, 2012).

The quality and distribution of many PrH/SDH are in decline. Income and wealth inequality is increasing as are job insecurity, temporary and part-time work (Curry-Stevens, 2009; Tremblay, 2009). Since 2000 wages have stagnated for 60% of the population and for those not employed, unemployment and social assistance benefits continue to fall behind the rate of inflation (National Council of Welfare, 2010). As a result food and housing insecurity is growing (McIntyre and Rondeau, 2009; Shapcott, 2009). As an overall indicator of the PrH/SDH situation, consider that 50% of Canadians would have difficulty meeting their financial obligations if their paycheck was delayed by 1 week (Nanos Research, 2012). Much of this is due to the lack of public policy that manages the activities of the business and corporate sector (Bryant *et al.*, 2011). Canadian governments' tax reductions have also made less resources available for governments to address PrH/SDH issues through HPP (Langille, 2009).

Interestingly, public attitudes have not shifted in parallel with governmental tax reductions. In fact, Canadians are willing to pay more taxes and tax the rich to reduce inequality, yet these views have not influenced Canadian governments to do so (Fitzpatrick, 2012; Ipsos Reid, 2013). In addition, there is public concern with growing inequality that offers a means of remobilizing the Canadian public to pressure governments to respond (Vincent, 2014).

Canadian researchers and advocates' activities usually work within a *pluralist* model of policy change by which the quality of ideas and related evidence are seen as shaping forms of public policy (Bryant *et al.*, 2011). Creating and providing evidence to policymakers as to the benefits of PrH/SDH-related HPP should assure implementation of such policy. Pluralism seems an adequate approach when the interests of the business and corporate, organized labour and civil society sectors are balanced such as appears to be the case in the Social Democratic and the

stronger Conservative welfare states, but falls short when public policy is made in the service of the business and corporate sector in the Liberal welfare states. It certainly has not led to PrH/SDH-related HPP in Canada.

A *materialist* analysis of public policymaking however draws attention to these power and influence imbalances (Bryant, 2009). David Langille for instance argues the deterioration of the quality and distribution of the PrH/SDH has come about through macro-level changes in economic policy spurred on by political specific actors (Langille, 2009). Systematic attacks on organized labour have strengthened the power and the influence of the business and corporate sector making it difficult to resist retrenchment of welfare programmes that provide economic and social security.

### THE VALUE OF IDENTIFYING HPP OPPONENTS

Knowing this, what is the value of explicitly identifying these opponents of PrH/SDH-related HPP? Various PrH/SDH discourses exist, each

of which has implications for the form and content of HPP. Some limit HPP to issues associated with access to necessary services and promoting healthy behaviours among those exposed to adverse PrH/SDH. Others emphasize building HPP that address the distribution of the PrH/SDH and identifying ideological barriers to implementing such HPP (see Table 1).

But the specific issue examined here is to what extent is it helpful to identify those ‘villains’ who promote HPP that skews the distribution of PrH/SDH? (Discourse 7 in Table 1). In this approach individuals and groups who through their undue influence upon governments create and benefit from the less equitable distribution of PrH/SDH are identified. As example, it can be argued that since the corporate and business sector in Canada lobby for (i) shifting the tax structures to favour itself and the wealthy; (ii) reducing public expenditures that benefit the majority of the population; (iii) controlling wages and limiting employment benefits and (iv) relaxing labour standards and protections, they should be identified as opponents of the PrH/SDH-related HPP enterprise (Chernomas and Hudson, 2007; Langille, 2009).

**Table 1:** Varying discourses on HPP and the distribution of the PrH/SDH

PRH/SDH discourse	Key concept
1. PRH/SDH as identifying those in need of health and social services	Health and social services should be responsive to peoples’ material living circumstances. HPP aims to improve access and quality of these services
2. PRH/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. HPP aims to make the healthy choice the easy choice
3. PRH/SDH as indicating the material living conditions that shape health	Material living conditions operating through various pathways – including biological – shape health. Implicit assumption that policymakers will respond to evidence with appropriate HPP
4. PRH/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. Implicit assumption that policymakers will respond with appropriate HPP
5. PRH/SDH and their distribution as results of public policy decisions made by governments and other societal institutions	Public policy analysis should form the basis of PRH/SDH analysis and advocacy efforts. Explicit call for the making of HPP to address these issues
6. PRH/SDH and their distribution result from economic and political structures and justifying ideologies	Public policy that shapes the PRH/SDH reflects the operation of jurisdictional economic and political systems. Explicit call for the making of HPP to address these issues with recognition that nations tend to follow established public policy paths
7. PRH/SDH and their distribution result from the power and influence of those who create and benefit from health and social inequalities	Explicit call for the making of HPP to address these issues with recognition that specific societal sectors both create and benefit from the existence of social and health inequalities. Need to identify these opponents and build political and social movements to defeat them in the public policy domain

But, who exactly are these specific actors and how can we reduce their undue influence upon public policy? Langille (Langille, 2009) identifies the business and corporate sector and their allies: business associations, conservative think tanks, citizen front institutions and conservative lobbyists as culpable:

The driving forces shaping our social determinants of health have been the owners and managers of major transnational enterprises—the men who have defined our corporate culture and wielded an enormous influence over public policy. Their main instrument has been macroeconomic policy, which they have used to set constraints on the role and scope of government. They have pushed for Canadian governments to adopt a free market or neo-liberal approach to macroeconomic policy (p. 305).

Langille argues that promoting PrH/SDH-related HPP can be achieved by educating and organizing citizens to *force* policymakers to promote health through HPP (Wright, 1994). This approach is not new and is seen in particularly pointed analysis of the political economy of health from the mid-1850s right up to the present (see Appendix). What does this analysis add to efforts to promote PrH/SDH-related HPP? Is it more useful than assuming that good ideas and evidence would flow from such an analysis?

Since research and advocacy efforts should correct these imbalances in power and influence Langille (Langille, 2009) proposes educating the public and using their strength in numbers to promote HPP to oppose this agenda. Educating the public in regards to the PrH/SDH has not been a priority of any governing authorities in Canada and in response, grassroots activity has done so. On the public health front a local public health unit in Ontario created a video animation *Let's Start a Conversation about Health and Not Talk about Health Care at All* (Sudbury and District Health Unit, 2011). It has been adapted for use by no less than 14 other public health units in Ontario (out of the total of 36), numerous others across Canada and jurisdictions in the USA and Australia (Raphael, 2012a).

Mikkonen and Raphael created a public primer on the PrH/SDH entitled *Social Determinants of Health: The Canadian Facts* that has been downloaded over 200 000 times since April 2010; 85% of these downloads by Canadians (Mikkonen and Raphael, 2010). And a new Canadian organization *Upstream Action* aims to create a movement to

create a healthy society through dissemination to the public of evidence-based, people-centred ideas (Upstream, 2013). The purpose of these activities is to create a groundswell of public interest in and support for HPP that will *force* policymakers to take the PrH/SDH seriously.

Efforts are occurring in the workplace through greater union organization and increasing public recognition of the class-related forces that shape public policy (Zweig, 2000, 2004; Jackson, 2009, 2010). To this end, there is interest in building links between those concerned with creating HPP and the organized labour movement (Lewchuk *et al.*, 2008; Lewchuk *et al.*, 2013). Such an alliance is consistent with findings that PrH/SDH are more likely to be distributed equitably when the organized labour movement is strong (Navarro and Shi, 2001; Navarro, 2009).

Activities are also occurring in the electoral and parliamentary arena. Social democratic parties are more receptive to—and successful at—implementing public policies that reduce social inequalities and health inequities (Navarro and Shi, 2002; Swank, 2005; Brady, 2009; Raphael, 2012c). Therefore, the recent 2011 elevation of the social democratic New Democratic Party (NDP) in Canada to the Official Opposition in Ottawa is a positive development. The NDP intends to raise the PrH/SDH in its next election campaign (New Democratic Party of Canada, 2013). It has undertaken a cross-Canada consultation to develop means of raising this issue in the next national election scheduled for 2015.

Finally, identifying ‘villains’ can boost citizen motivation and build a social movement to improve the quality and equitable distribution of the PrH/SDH. Langille (Langille, 2009) argues:

By identifying the political actors behind what are often seen as impersonal market forces, citizens come to understand that progressive change is possible—and how they might improve the social determinants of health . . . If citizens are to reassert their power and restore democracy, they will first have to raise public awareness about the threat of corporate control (p. 305).

## IMPLICATIONS FOR BUILDING HPP THAT ADDRESSES THE PRH/SDH

The argument presented does not deny the importance of knowledge development and transmission and developing and applying models of policy analysis and change that can facilitate the

making of PrH/SDH-related HPP (Clavier and de Leeuw, 2013b). It does assert however that these activities must be buttressed by critical analyses of power relations within societies and how these power relations shape the politics of a society. These critical analyses may be less important in nations where these issues are less contentious. But even then, threats to HPP that equitably distribute the PrH/SDH are arising even in the social democratic Nordic nations (Raphael, 2014). These threats exist in the form of welfare state retrenchment associated with a return to behavioural approaches—or lifestyle drift—to health promotion (Backhans and Burstrom, 2012). Alternative approaches that mobilize the public and create pressure for PrH/SDH-related HPP and build support for the organized labour movement and parties of the left are necessary (Navarro and Shi, 2002; Raphael, 2012c).

Health promoters are faced with a difficult task. Most of their activities—especially if they are employed by the State—involve working to improve the quality and distribution of the PrH/SDH through individual interactions, community work and developing public policy recommendations that may be ignored (Raphael, 2006). If my analysis is correct, they will have to engage more directly in building social and political movements that can shift the distribution of influence and power (Raphael, 2012b). They may be able to do this through public education as part of their employment and urging their professional associations into a stronger advocacy role (Bryant *et al.*, 2007; Raphael, 2009a; Raphael *et al.*, 2008). They may also have to engage in political activity as citizens outside of their employment (Raphael, 2006, 2011).

To summarize, the importance of identifying the societal sectors who oppose PrH/SDH-related HPP and responding to these threats to HPP will be greatest in nations where the business and corporate sector hold greater sway: Canada, the UK and the USA (Scambler, 2002; Hofrichter, 2003; Chernomas and Hudson, 2007). The extent to which it is useful in other liberal nations such as Australia and New Zealand, the conservative nations of Continental Europe and the social democratic Nordic nations should be the subject of further analysis. Putting faces to ‘villains’ threatening the health of citizens can harness citizen energies in the service of PrH/SDH-related HPP. It can promote citizen engagement in all forms of the politics that can move this agenda forward. It may not be the

most pleasant or easiest way to conceive of and act upon the PrH/SDH through HPP, but may prove to be the most useful in the long term.

## APPENDIX. HISTORICAL CONTEXT: IDENTIFYING THOSE OPPOSING EQUITABLE DISTRIBUTION OF THE PRH/SDH

### Friedrich Engels

In view of all this, it is not surprising that the working-class has gradually become a race wholly apart from the English bourgeoisie. The bourgeoisie has more in common with every other nation of the earth than with the workers in whose midst it lives. The workers speak other dialects, have other thoughts and ideals, other customs and moral principles, a different religion and other politics than those of the bourgeoisie. Thus they are two radically dissimilar nations, as unlike as difference of race could make them, of whom we on the Continent have known but one, the bourgeoisie (Engels, 1845/1987).

In the *Condition of the Working Class in England* (1845) German political economist Friedrich Engels studied how poor housing, clothing, diet and lack of sanitation led directly to the infections and diseases associated with early death among working people in England. Engels identified material living conditions, day-to-day stress and the adoption of health-threatening behaviours as the primary contributors to social class differences in health. Engels was not benign in his critique: he used the term *social murder* to refer to the fact that these life-threatening conditions resulted from the operation of the economic system and that *[T]he bourgeoisie places hundreds of proletarians in such a position that they inevitably meet a too early and an unnatural death, one which is quite as much a death by violence as that by the sword or bullet.*

### Rudolf Virchow

The bureaucracy would not, or could not, help the people. The feudal aristocracy used its money to indulge in the luxury and the follies of the court, the army and the cities. The plutocracy, which draw very large amounts from the Upper Silesian mines, did not recognize the Upper Silesians as human beings, but only as tools or, as the expression has it, ‘hands.’ The clerical hierarchy endorsed the wretched neediness of the people as a ticket to heaven (Virchow, 1848/1985).

German physician Rudolf Virchow's was a trail-blazer in identifying how societal policies determine health. In 1848, Virchow's *Report on the Typhus Epidemic in Upper Silesia* argued that lack of democracy, feudalism, and unfair tax policies in the province were the primary determinants of the inhabitants' poor living conditions, inadequate diet and poor hygiene that fuelled the epidemic. He stated that *Disease is not something personal and special, but only a manifestation of life under modified (pathological) conditions*. Arguing *Medicine is a social science and politics is nothing else but medicine on a large scale*, Virchow drew the direct links between politics, social conditions and health. *If medicine is to fulfil her great task, then she must enter the political and social life. Do we not always find the diseases of the populace traceable to defects in society?*

### Graham Scambler

The GBH (Greedy Bastards Hypothesis) states, without a hint of hyperbole, that Britain's persisting – even widening – health inequalities might reasonably be regarded as the (largely unintended) consequences of the ever-adaptive behaviours of its (weakly globalized) power elite, informed by its (strongly globalized) capital executive (Scambler, 2002).

British sociologist Graham Scambler developed the Greedy Bastards Hypothesis (GBH) in order to make explicit that class did matter and that one particular class was shaping public policy in their service with adverse health effects for most others. In his analysis, growing health inequalities are the results of the activities of a 'core "cabal" of financiers, CEOs and Directors of large and largely transnational companies, and rentiers'. More recently Scambler has written: *So the GBH charged leading capitalists and politicians with what the likes of Engels and Virchow in the nineteenth century called homicide. As Michael Marmot has more recently averred, policies can kill, and when these are reflexively enacted their architects shouldn't be surprised to find themselves liable to prosecution in the event of a regime change* (Scambler, 2012).

### David Coburn

Contemporary business dominance, and its accompanying neo-liberal ideology and policies, led to attacks on working class rights in the market (e.g.,

by undermining unions) and to citizenship rights as expressed even in the liberal (market-dependent) version of the welfare state enacted in most of the Anglo-American nations. Labour's lessened market power and fragmentation, and the shredding of the welfare state also led to major increases in social inequality, poverty, income inequality and social fragmentation [(Coburn, 2004), p. 44].

Canadian sociologist Coburn describes how the power of capital in the form of economic globalization and justified through neo-liberal ideology acts through form of the welfare state to shape the quality and distribution of the PrH/SDH. His initial work on neo-liberalism provoked much debate and continues to influence the field (Coburn, 2000). Coburn places his work firmly within the materialist political economy tradition.

### Robert Chenomas and Ian Hudson

Income power and privilege have been shifted towards those who own and control the corporate world and away from the majority of the North American public, with the express democratic consent of that very public... The current conservative policy environment has made our society less healthy, more dangerous, less stable, more unequal, less fair, and more inefficient (Chenomas and Hudson, 2007).

These Canadian economists argue in *Social Murder and other Shortcomings of Conservative Politics* (2007) that corporate power and the ideology that justifies it has come to dominate public policy. The approach is not only misguided and wrong but responsible for increased illness and death and the suffering that goes with it. They state: *Most readers will no doubt be aware that modern corporations have acquired such vast power that they are above the law – or more precisely that they have a huge influence on what the law says – and that this has many harmful effects on the public and the environment* (pp. 6–7).

### Vicente Navarro

It is not inequalities that kill, but those who benefit from the inequalities that kill. The Commission's studious avoidance of the category of power (class power, as well as gender, race, and national power) and how power is produced and reproduced in political institutions is the greatest weakness of the report... It is profoundly apolitical, and therein lies the weakness of the report [(Navarro, 2009), p. 15].

Political economist Vicente Navarro's work focuses on how politics and political ideology and how they influence governance within capitalist economies are important sources of the public policies that create health inequalities. As editor of the *International Journal of Health Services*, he provides a forum for critical analyses of the political economy of health. Three volumes bring together many of these articles (Navarro, 2002, 2007; Navarro and Muntaner, 2004).

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