Ideas At The Margin Or Marginalized Ideas? Nonmedical Determinants Of Health In Canada

Policymakers outside Canada’s health sector have not made much use of what is known about the health effects of their policies.

by John N. Lavis

Beginning with the release of the Lalonde report in 1974, Canadian policymakers and researchers have been continually exposed to ideas about the nonmedical determinants of health. The core substance of these ideas has remained remarkably constant over the years. At their simplest, these ideas highlight the importance of nonmedical factors such as income, employment, and social support in explaining the level and distribution of health in populations. Health care explains why some people get well after they are sick; nonmedical factors appear to explain a large part of why some people are healthy and others are not.

The language used to discuss ideas about nonmedical determinants of health has, however, changed with each passing decade. Canadian policymakers and researchers talked about “health fields” in the 1970s, “health promotion” in the 1980s, and “population health” in the 1990s. So while their U.K. colleagues framed these ideas negatively with talk of “health inequalities,” and their U.S. colleagues tried to keep the debate on neutral terms with talk of the “socioeconomic gradient” or “society and health,” Canadians have emphasized the positive side: working in neglected health fields, promoting health, and improving (or seeking efficiencies in the production of) population health.

A casual observer of the Canadian scene would be impressed by the extent to which these positively framed ideas appear to have had an impact on Canada’s policy landscape. Federal and provincial health departments have been reorganized to create population health divisions or business lines. These departments have jointly created the Federal, Provincial, and Territorial Advisory Committee on Population Health, which now uses these ideas to inform how it presents data on the health of Canadians. Canada’s statistical agency used these ideas to inform the development of two new longitudinal health surveys: the National Longitudinal Study on Children and Youth, and the National Population Health Survey. Even health-related interest groups have repositioned themselves. For example, the Canadian Pharmacoepidemiology Forum has become the Canadian Association for Population Therapeutics.

A casual observer also would be impressed by the apparent impact of ideas about nonmedical determinants of health on Canada’s research landscape. The country’s principal funder of health research has been transformed over the past five years, with nonmedical determinants of health now constituting one of the four “pillars” of the new Canadian Institutes of Health Research and the focus for two of its peer review commit-
tees. As well, the federal government created the Canadian Population Health Initiative to fund research and knowledge-transfer activities in this area. New research programs have been created within existing organizations such as the Canadian Institute for Advanced Research, and even new research organizations have been created, such as the Saskatchewan Population Health Evaluation and Research Unit. New data sets have been created in the provinces (for example, Manitoba and British Columbia) to facilitate research on nonmedical determinants of health.

A more detailed look at the Canadian scene, however, suggests a different story. What unites the above-cited activities is how firmly rooted they are in the health sector. And yet the main implications of nonmedical determinants of health lie outside the health sector, in policy sectors (such as finance, labor, and social services) that can influence people’s income, employment opportunities, and social supports. For example, policymakers in finance departments seek to influence poverty and unemployment rates. Research about the health consequences of economic policies could influence policy making at the margin by informing trade-offs between policy alternatives that can be expected to achieve their economic objectives.

The litmus test for the impact of ideas on nonmedical determinants of health is whether they have had an impact on the health of Canadians. To conduct this test, I describe changes in the level and distribution of health in Canada over a twenty-five-year period and then assess the links in a causal chain that would have to be established to confirm that any changes in health are attributable to action on the basis of these ideas. Working backward from impacts on health to the ideas themselves, the links include the influence of these ideas on policy making outside the health sector, the presence of these ideas in policy-making environments outside the health sector, and the clarity of the messages for policymakers.

**Changes In The Health Of Canadians, 1971–1996**

If poverty, unemployment, and social isolation have been found to lead to poor health, then action on the basis of these ideas could be expected to lead over time to an increase (or to a slowing in the rate of decrease) in the level of health in a population or to a reduction in the difference in health status between rich and poor, employed and unemployed, or socially supported and socially isolated, other things being equal. But therein lies the rub: Other things are never equal. Even the best available data sets and analytic techniques cannot account entirely for competing explanations (for example, improvements in the availability and quality of health care and action consistent with but not attributable to these ideas); health-related selection into and out of poverty, unemployment, and social isolation; and latency effects that vary by the type of action and anticipated health impact.

Russell Wilkins and his colleagues at Statistics Canada recently examined changes in the level and distribution of health status in urban Canada from 1971 to 1996. They used a variety of mortality measures (infant and adult mortality, life expectancy at birth, probability of survival to age seventy-five, and potential years of life lost) for all causes of death and selected causes, and they examined time trends in both rates and rate ratios between the top and bottom income quintiles. The time period starts after the introduction of publicly financed hospital and physician services in Canada (Medicare) but before policymakers were exposed to ideas about nonmedical determinants of health, and it ends during a period of public-sector retrenchment.

The mortality pattern over time is largely consistent with what we expect would have happened if ideas about nonmedical determinants of health had been acted upon in Canada. Between 1971 and 1996 mortality rates dropped for all income quintiles, for both sexes and for most causes of death (with the exception of breast cancer for women, prostate cancer for men, and injuries from motor
vehicle accidents for both sexes). Mortality differentials between rich and poor generally persisted over time, although the differentials tended to become smaller, particularly for women. Declines in mortality rates and inequality across income groups continued steadily over the period for some causes of death, occurred very early in the study period for others, and accelerated in recent years for still others.

But the story is not entirely one of progress. Mortality rates were higher and inequality greater over time for a few causes of death: lung cancer for women and mental disorders, AIDS, and ill-defined conditions for both sexes. These changes for the worse tended to occur over the past five to ten years, a time when health care spending in Canada was falling, the prevalence of low income was rising, and unemployment rates were dropping. These factors can hardly account for changes in lung cancer rates for women, however, a finding for which one must look back several decades for an explanation. Sorting out the causes of changes over time is a complex undertaking and one for which comparing similar data across multiple countries would only be a partial solution.

**Influence On Nonhealth Policy Making**

Now, let us step back from examining changes in health to examine the influence of ideas about nonmedical determinants of health on policy making outside the health sector, a link in the causal chain that would have to be established to confirm that any changes in Canadians' health are attributable to (and not just consistent with) action on the basis of these ideas. The power of these ideas comes from their potential to influence the development of nonhealth public policies by adding health to the list of possible outcomes when policy alternatives are being evaluated. The test of the influence of these ideas on policy making would therefore be to identify whether these ideas have played a role at the margin, for example, by informing a decision in the finance sector that otherwise would have been informed by an assessment of economic and political considerations.

The only Canadian case-study research on this issue has found that ideas about the nonmedical determinants of health have not had a powerful influence on either agenda setting or policy development outside the health sector. Of the five cases of policy change that were cited as having been informed by these ideas, only two cases involved policy changes outside health, and only one of these policy changes was influenced by these ideas. But this case—the decision to pool the human services budgets in Prince Edward Island, justified in part on the grounds that such a change would facilitate cross-sectoral resource allocations in line with the determinants of health—turned out to constitute a symbolic use of these ideas. Ideas about nonmedical determinants of health did not influence the policy decision per se but instead were invoked to build support for a decision made for other reasons.

Many Canadian policymakers and researchers would argue that the National Children’s Agenda was informed by ideas about nonmedical determinants of health, particularly research on early childhood development. This policy development process constitutes an excellent example of how policymakers and researchers can work closely together to understand a problem’s causes and the options for addressing it. No one has yet examined the case in a systematic way, however, to ascertain whether research on early childhood development was influential in the policy-making process and, if so, through what mechanisms and why. At best we can say that the actions were consistent with these ideas and offer hypotheses about why the ideas may have been influential.

**Presence Of Ideas In Policy-Making Environments**

We now examine whether and how ideas about nonmedical determinants of health have permeated the highest levels of Canadian government. After all, perfectly good ideas can be trumped by many other considerations.
For example, who wins, who loses, and by how much, as well as assessments of the administrative capacities of government departments, can influence the identification and selection of policy alternatives. Surveys of legislators’ and policy advisers’ awareness of and attitudes toward these ideas provide a reasonable test of whether the ideas are reaching people who can act on them and what they think about them, with the caveat that their responses may be affected by a social desirability bias (that is, they may tell us what they think we want to hear).

In a recent survey of Canadian federal and provincial policy advisers in finance, labor, social services, and health, our preliminary findings suggest that advisers in labor and social services saw health as a relevant outcome for their sector. More than 80 percent of them felt that they should consider health determinants in all government initiatives, and (quite surprisingly given that one would expect economic and social outcomes to trump health outcomes in those two sectors) more than 60 percent of them disagreed with the statement that there are more important considerations in policy making than a policy’s impact on health. More than half of these advisers were not willing to see their responsibilities for improving health relegated to health departments.

Policy advisers in finance were another matter. Ideas about nonmedical determinants have largely failed to permeate this sector of Canadian government, where much of their potential lies. These departments establish tax-and-transfer policies, influence the broader macroeconomic environment that in turn influences labor markets, and hold the financial reins on other departments’ spending. The finance advisers who completed surveys (and are therefore more likely to be interested in these ideas) were much less convinced than their counterparts in other sectors that health determinants should be considered in all major government initiatives. Also, they were much less aware of research on the impact of specific nonmedical determinants on health, and much less likely to support investments in more research or in policy action.

Clarity Of The Messages For Policymakers

Now we step back one last time to examine the final link in the causal chain that would have to be established to confirm that any changes in the health of Canadians are attributable to action on the basis of ideas about nonmedical determinants of health. Here we come to the clarity of the messages for policymakers and the social groups that seek to influence them. Past research on the role of ideas in policy making has tended to focus on bodies of research knowledge from which clear messages have been derived for policymakers, such as Keynesian ideas about recessions and the benefits of countercyclical demand management. The test of the clarity of messages about nonmedical determinants of health therefore would be whether researchers could specify the underlying causes of problems and the policy options to address them.

Unfortunately, the messages coming out of research on nonmedical determinants of health are anything but clear. For one thing, these ideas have evolved over time. For example, “health promotion”—the dominant version in the 1980s—tends to advocate a more bottom-up approach to change, emphasizing public policy as only one of five strategies to improving health. “Population health”—the dominant version in the 1990s—tends to adopt a more top-down approach to change, often emphasizing public policy at the expense of other options. This observation casts doubt on our ability to assess the impact of ideas about nonmedical determinants of health on the health of Canadians over the past twenty-five years. No single body of ideas existed over that time period in Canada.

Moreover, while we have a great deal of evidence about the associations between poverty and health, unemployment and health, and social isolation and health, we have few evaluations of how specific policies that address these three conditions affect health and
the other economic and social outcomes that matter to us. Without this information, we cannot inform trade-offs outside the health sector. In our survey of Canadian federal and provincial policy advisers, respondents from all sectors agreed on one area—what is now needed to act on these ideas: More than 80 percent indicated that they need more information about effective interventions. To put this another way, they need information about the health consequences of the policy alternatives that their departments face. This observation also casts doubt on our ability to assess the impact of ideas about nonmedical determinants of health. No body of actionable messages exists.

Weak Links In The Causal Chain

It is extremely unlikely that changes in the level and distribution of health in Canada during 1971–1996 can be attributable to action on the basis of ideas about nonmedical determinants of health. The links in a causal chain that connects these ideas to the health of Canadians are far too weak. We have no evidence that these ideas have influenced policy making outside the health sector. We do have evidence that these ideas are absent from or not well regarded in finance departments, an important policy-making environment outside the health sector. And we have lacked a stable body of actionable messages for policy-makers and the groups in society that seek to influence them.

If nonmedical factors such as income, employment, and social support can explain a substantial part of the variation in the level and distribution of health in populations, then research should begin to focus on the health consequences of tax-and-transfer policies, labor market policies, and social service policies. If it did, perhaps the findings from such research could help to inform trade-offs between policy alternatives. A minimum wage policy may be chosen over a tax-and-transfer policy, for example, if both policies are expected to achieve desired economic objectives but the former leads to better health outcomes. In the absence of such research, these ideas have remained marginalized in Canada, neither relevant to the health sector where a few of their policy implications lie nor sufficiently well developed to apply beyond the health sector where most of their implications do lie.

However, a reorientation in the trajectory of Canadian research programs on the nonmedical determinants of health may not happen spontaneously, at least if the past twenty-five years is any indication. Canadian health policymakers will need to either “fish or cut bait” on these ideas. Fishing will involve selectively funding policy-relevant research that can inform trade-offs in nonhealth sectors, for example, by paying for health outcomes to be added to the list of outcomes being considered when policy evaluations are being conducted in nonhealth sectors. Cutting bait will involve getting back to their core area of responsibility: the health care system. Researchers also face a choice: Either they can rethink the questions they are asking and seek to produce and transfer ideas relevant to the margins of nonhealth sectors, or they can continue to see their ideas marginalized.

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NOTES

1. M. Lalonde, A New Perspective on the Health of Canadians (Ottawa: Minister of Supply and Services Canada, 1974). I use the term ideas, as opposed to research, to reflect that policy advisers are more likely to encounter research in the form of ideas than in the form of specific studies. See, for example, C.H. Weiss, “Policy Research: Data, Ideas, or Arguments?” in Social Sciences and Modern States: National Experiences and Theoretical Crossroads, ed. P. Wagner et al. (Cambridge: Cambridge University Press, 1991), 307–332.

helpful next step would be to study the factors that may explain patterns of action and inaction in addressing the social determinants of health, the physical determinants of health, and more traditional causes of morbidity and mortality such as motor vehicle accidents and smoking.3


7. J.N. Lavis and T.J. Sullivan, “Governing Health,” in Market Limits in Health Reform: Public Success, Private Failure, ed. D. Drache and T.J. Sullivan (London: Routledge, 1999), 312–328. While policy-makers at the municipal or regional level, businesses, and community-based organizations can affect some nonmedical determinants of health, federal and state/provincial governments clearly have the most potential to affect them.


9. Psychologists have long recognized decision-makers’ tendency to restrict the number of consequences considered. This failure to examine multiple consequences simultaneously, often called noncognitive, is pervasive because of the cognitive difficulty required in undertaking such complex considerations. E. Shafer and A. Tversky, “Thinking through Uncertainty: Nonconsequential Reasoning and Choice,” Cognitive Psychology 24, no. 4 (1992): 449–474.


14. Some hypotheses about why research about early childhood development became influential in the policy-making process include the strength of the evidence base, the clarity of the messages for policymakers (some intervention studies exist), the linkage between these messages and catchy political rhetoric (“by investing in our kids, we’re investing in our future economic growth”), and the existence of a broad-based coalition that supported the change.


16. Some hypotheses about why policy advisers in labor and social services are more aware of and disposed toward ideas about nonmedical determinants of health include the synergies between economic and health outcomes in their sectors, their general focus on the well-being of workforces and clients as opposed to the well-being of the economy, and that knowledge-transfer efforts have been more effectively targeted at them.


18. Lavis et al., “Do Canadian Policy Advisers Care about Health?”