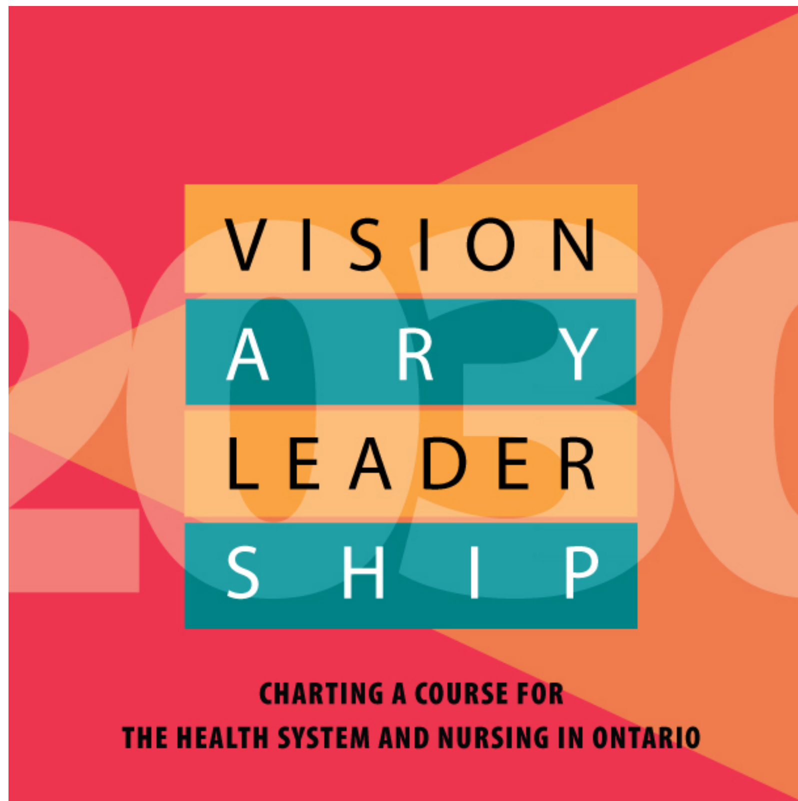
RNAO Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers autorisés de l'Ontario
Speaking out for nursing. Speaking out for health.



Public Health

RNAO Vision backgrounder

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Key Issue

In 1946, the World Health Organization Constitution asserted the "the highest standards of health should be within reach of all, without distinction of race, religion, political belief, economic or social condition."[1 2] This human rights approach is captured now by the concept of health equity which means that all people can achieve their full health potential and not be disadvantaged from achieving it because of their social position or other socially determined circumstance.[3] Health inequities then are "health differences that are socially produced; systemic in their distribution across the population; and unfair."[4]

In a world where the life expectancy at birth[5] in Japan is 83 years compared to the Democratic Republic of the Congo where it is 49 years, Canada's life expectancy at birth ranks among the highest at 81 years.[6] Within our relatively privileged country, Ontario's life expectancy at birth is 81.5 years for both sexes, 79.2 years for males, and 83.6 years for females, all slightly higher than the Canadian average.[7]

What is hidden in the aggregated numbers between and within societies is that differences in health inequities are directly linked to social inequities. In Hamilton, for example, there is a 21 year difference in life expectancy between a low-income neighbourhood at 65.5 years and an affluent neighborhood only five kilometers away where the life expectancy is 86.3 years.[8] In 2001,[9] the life expectancy at birth for Inuit women was 71.7 years, First Nations women was 76.7 years, Métis women was 77.7 years, and non-Aboriginal women was just over 82 years.[10] Those who are most disadvantaged in any society have the worst health outcomes. Not only do people who are living in poverty and social exclusion experience a greater burden of disease and die earlier but there is also a dose-response along the social gradient that affects us all.[11] "Put simply, the higher one's social position, the better one's health is likely to be."[12]

Action on the social determinants of health such as income; employment/unemployment/working conditions; food security; housing; healthy and inclusive neighbourhoods; racism/discrimination; work-life balance/unpaid work; social support/social capital; and stress/allostatic load is needed to achieve health equity in Ontario.[13] The Project for an Ontario Women's Health Evidence-Based Report noted that if everyone had the same health as Ontarians with higher incomes, an estimated 3,373 fewer people would die each year among those living in metropolitan areas.[14]

Canada has been widely recognized as an early and influential leader in understanding upstream approaches to address population health inequities.[15 16 17 18 19 20] Despite this promising start, other jurisdictions, particularly in Europe,[21 22 23] have been more successful in rising to the World Health Organization's Commission on the Social Determinants of Health's ethical imperative to close the health equity gap.[24] According to the World Health Organization, "social injustice is killing people on a grand scale:"[25]

> The poor health of the poor, the social gradient in health within countries, and the marked health inequities between countries are caused by the unequal distribution of power, income, goods, and services, globally and nationally, the consequent unfairness in the immediate, visible circumstances of people's lives—their access to health care, schools, and education, their conditions of work and leisure, their homes, communities, towns or cities—and their chances of leading a flourishing life. This unequal distribution

of health-damaging experiences is not in any sense a 'natural' phenomenon but is the result of a toxic combination of poor social policies and programs, unfair economic arrangements, and bad politics.[26]

The public health sector, especially nurses working in public health, have the potential to play a transformative role in saving lives by reducing the preventable health gap caused by social injustice.

Registered Nurse and Nurse Practitioner Positions in Public Health Units[27]

RNs:

Public Health Unit/Department	Full time Employment	3,025	74.14
	Part time Employment	563	13.80
	Casual Employment	492	12.06
Totals:		**4,080**	**100**

NPs:

Public Health Unit/Department	Full time Employment	36	57.14
	Part time Employment	15	23.81
	Casual Employment	12	19.05
Totals:		**63**	**100**

Enablers

Building on decades of international evidence,[28] [29] the World Health Organization's Commission on Social Determinants of Health identified three principles of action to reduce health inequities:

- improve the conditions of daily life—the circumstances in which people are born, grow, live, work, and age
- tackle the inequitable distribution of power, money, and resources—the structural drivers of those conditions of daily life—globally, nationally, and locally
- measure the problem, evaluate action, expand the knowledge base, develop a workforce that is trained in the social determinants of health, and raise public awareness about the social determinants of health[30]

To build movement for this framework and the 2009 World Health Assembly resolution WHA62.14 "Reducing health inequities through action on the social determinants of health," [31] the World Health Organization (WHO) convened the World Conference on Social Determinants of Health[32] in Rio de Janeiro, Brazil. Heads of government, ministers, and government representatives from 125 member

states[33] adopted the Rio Political Declaration on Social Determinants of Health on October 21, 201 to "solemnly reaffirm our resolve to take action on social determinants of health to create vibrant, inclusive, equitable, economically productive and healthy societies."[34] Since the World Conference, the World Health Assembly reaffirmed "the political will to make health equity a national, regional and global goal"[35] and WHO "observed a considerable increase in the action on social determinants of health."[36] Participants at the 2013 Global Conference on Health Promotion "prioritize health and equity as a core responsibility of governments to its peoples, affirm the compelling and urgent need for effective policy coherence for health and well-being, and recognize that this will require political will, courage and strategic foresight."[37]

Moving to Canada, it is significant that the theme of the first report of Canada's first Chief Public Health Officer, David Butler-Jones, was organized around addressing health inequalities.[38] The mission of the Canadian Institutes of Health Research of Population and Public Health is "to improve the health of populations and promote health equity in Canada and globally through research and its application to policies, programs, and practice in public health and other sectors."[39] In addition to supporting the work of the WHO Commission on Social Determinants of Health, [40] the Public Health Agency of Canada funds six National Collaborating Centres for Public Health with priority areas of: Aboriginal health; determinants of health; environmental health; healthy public policy; infectious diseases; and methods and tools.[41] The National Collaborating Centre for Determinants of Health (NCCDH) commissioned an environmental scan[42] that affirmed the vital role that public health leaders and organizations play in advancing health equity.[43] Three NCCDH initiatives related to population health status reporting, public health leadership, and promising practices to advance health equity[44] have generated resources that link public health and health equity.[45] [46] [47] [48] [49]

In Ontario, potential health equity enablers include Kathleen Wynne's aspiration to be the "social justice premier,"[50] the existence of the Cabinet Committee on Poverty Reduction and Social Inclusion[51] and the unanimous support by all three parties for Ontario's *Poverty Reduction Act, 2009.*[52] The goal of *Ontario's Action Plan for Health Care* "is to make Ontario the healthiest place in North America to grow up and grow old."[53] The *Excellent Care for All Act, 2010* (and not just for some Ontarians) recognizes "that a high quality health care system is one that is accessible, appropriate, effective, efficient, equitable, integrated, patient centred, population health focussed, and safe."[54] Ontario's Chief Medical Officer of Health advocates that a health lens be applied to every policy and program at the provincial, regional, and municipal levels so that "we can be clear on the health benefits or potential impacts of everything we do."[55] The mission of Public Health Ontario is to "enable informed decisions and actions that protect and promote health and contribute to reducing health inequities."[56] This is consistent with the mission of Ontario's Public Health Sector Strategic Plan "to protect and promote the health of all people in Ontario through the delivery of quality public health programs and services, effective partnerships and a focus on health equity." [57] According to the *Ontario Public Health Standards,* "addressing determinants of health and reducing health inequities are fundamental to the work of public health in Ontario."[58] There are health units in Ontario whose work on health equity is exemplary. As one illustration, the WHO spotlighted Sudbury & District Health Unit's video animation, "Let's Start a Conversation about Health,"[59] at the World Conference on Social Determinants of Health in Brazil[60] and it has been adapted by other health units within Ontario, nationally, and internationally. The province of Ontario has invested in improving health equity through such means as funding the Population Health Improvement Network,[61] developing decision support tools such as the Health Equity Impact

Assessment,[62] and supporting two social determinants of health nurses for each of the 36 public health units.[63] There is a growing expectation that Local Health Integration Networks (LHINs) will be a means of operationalizing improvements in health equity[64] by moving increasingly from strategy to practice within their specific communities.[65] [66]

Public Health Units can have a significantly higher impact on Ontarians and their health system by tightening its alignment with the LHINs. This is why RNAO in its submission[67] to the Standing Committee on Social Policy's review of the *Health System Integration Act (LHSIA)* proposed that including Public Health Units under *LHISA* will be critical to advancing the LHIN's role in addressing health equity, health promotion and disease prevention. Public Health Units hold the social determinants of health as a core of their work and have significant expertise in mobilizing and engaging communities with an emphasis on vulnerable populations. When the LHINs were first developed in 2006, RNAO joined the voice of others to support excluding Public Health Units from the LHIN mandate. This advocacy was grounded in concern that the core of public health would be eroded within an 'illness-based system' and overshadowed by the hospital system. Those concerns had a time and a place; however, our health system is evolving at an unprecedented pace and demands an emphasis on health promotion that can only be achieved through an accountability relationship between public health units and LHINs. Moving forward, we recommend transitioning the reporting relationship of Public Health Units from the Ministry of Health and Long-Term Care to LHINs keeping in mind the following imperatives:

i. Public Health Unit funding not be reduced;

ii. Public health specific programming not be eliminated;

iii. The identity and mandate of public health as 'health promotion and disease prevention' be fully retained to enable a more well defined balance with an 'illness-based care system';

iv. The local governance model (i.e. Board of Health) must remain and the dual reporting relationship be preserved (Public Health Units would report to the LHIN and the local municipality).

"Public health nursing practice is rooted in the core value of social justice."[68] "The practice of community health nursing combines nursing theory and knowledge (including social sciences and public health science) with home health and primary care principles. The nursing metaparadigm includes: the person (individuals, families, communities, groups, and populations), health, nursing, environment [culture] and social justice as central to the practice of community health nursing."[69] With social justice as a core value[70] and a key aspect of nursing knowledge, actions to address health inequities are supported by community health nursing standards,[71] public health nursing discipline specific competencies,[72] code of ethics,[73] regulatory standards,[74] and nursing associations.[75] [76] [77] [78] [79] [80] [81] Canada,[82] [83] [84] [85] [86] and specifically Ontario, is home to a rich foundation of nursing (and non-nursing)[87] knowledge and expertise in education, research, and practice related to health equity.[88] [89] [90] [91] [92] [93]

The three models of implementation that have emerged from Ontario's Social Determinants of Health Nurses Initiative since it started in 2011 are: working with priority communities or populations; working on specific health equity or social determinants of health topics; and organizational capacity building.[94]

These may be either stand-alone or in combination and are illustrative of elements of the Critical Caring Theory framework, which serves to "make explicit the bridging of theory to practice within their work."[95] As with many other nurses working on health equity within public health and across sectors, there is "an intricate dance of meeting basic needs downstream, either directly or indirectly, through linking people with existing resources and moving upstream to advocate for healthy public policy."[96]

Barriers

As the "causes of the causes" of health inequities are structurally located within a social, economic, and political context that generates stratification through key institutions and processes,[97] it is important to situate this discussion within the dynamics of globalization. Modern globalization has been described as an accelerated movement of information, goods, capital, and people across geographical and political borders.[98] The underlying ideology of economic globalization is neoliberalism,[99] which asserts that market forces, left unfettered, lead to optimal societal outcomes.[100] By defining government as the problem for society, Ronald Reagan, Margaret Thatcher, and Brian Mulroney implemented neoliberal reforms of deregulation, privatization, trade liberalization, erosion of fiscal capacity through tax cuts, and shrinking of social programs.[101] Globalization plays a role in generating health inequities through four main mechanisms: social stratification, differential exposure, differential vulnerability, and differential consequences.[102] While vast wealth has been created by contemporary globalization, the economic benefits have been "largely asymmetrical, creating winners, losers and growing inequalities between the two."[103] The result is a global situation where almost half (46 per cent) of the world's wealth is owned by just one per cent of the population.[104] Incredibly, the bottom half of the world's population (the 3.5 billion poorest) owns less than the richest 85 people on the planet.[105] After a momentary dip, the global elite are recovering well after the recent financial recession. In the United States, for example, between 2009 and 2012, the wealthiest one per cent captured 95 per cent of post-financial crisis growth, while the bottom 90 per cent became poorer.[106] Rising economic inequality is a "major risk to human progress" as when political institutions are captured by the wealthy, "the rules bend to favor the rich, often to the detriment of everyone else."[107] "Cascading privilege"[108] consolidates access to opportunities for those who are already advantaged across generations thereby leading to the erosion of democratic governance, the fraying of social cohesion,[109] and, of course, rising health inequities.

The global financial crisis of 2008, like the more than 200 financial crises that occurred globally over the last thirty years, can be directly linked to regulatory and restructuring processes arising from the ascent of neoliberal policy solutions.[110] It has been persuasively argued that "the real danger to public health is not recession per se, but austerity."[111] Iceland was "rocked by the worst bank crisis in history" but did not experience rising deaths during the recent recession. Unlike Iceland which bolstered its social safety net, Greece became "Europe's guinea pig for austerity" as massive funding cuts were made. The human costs were rising homicides, a doubling in suicide, a 52 per cent rise in HIV, and a return of malaria at the same time as critical public health programs were cut.[112] The global financial crisis is having a deleterious impact on health equity in Canada[113] and in Ontario[114] through two main pathways. The first is through austerity budgets with their associated program and service cuts in the public sector including affordable housing, education, health care, and social assistance.[115] The second pathway is through

labour market transformations towards more precarious forms of employment, which are often low-waged and without benefits.[116] It is estimated that the direct and indirect effects of the shift to austerity in 2012 with fiscal reductions from all three levels of government could reduce Ontario's GDP by a total of 3 per cent over the next few years.[117] [118] The ongoing health impacts of rising economic inequities, the declining middle class,[119] and increasing invisibility of the most marginalized people are increasing difficult to evaluate due to the federal government's evisceration of the long-form census.[120]

Despite Canada's reputation as a "health promotion powerhouse," Canada "lags well behind other wealthy developed nations"[121] in moving from evidence to action on health equity.[122] One of the more intransigent barriers to reducing health inequities is "lifestyle drift"—"the tendency for policy to start off recognizing the need for action on upstream social determinants of health inequalities only to drift downstream to focus largely on individual lifestyle factors."[123] The phenomenon of lifestyle drift is "endemic in Canadian health promotion and public health."[124] It must be understood in the context of deeply entrenched neoliberalism that privileges an individualistic market model over a more community-based concept of society.[125] Lifestyle drift is further reinforced by the individualistic biomedical paradigm based on biological determinism and the "legitimation of social inequalities through personal responsibility."[126]

Improving health equity in "an increasingly inhospitable political climate"[127] is in itself a difficult challenge. Ted Schrecker raises the provocative point that perpetuating lifestyle drift may exacerbate health inequities:

> Health promotion initiatives that neglect structural influences on health and reinforce or legitimize neoliberal attributions of responsibility are not just irrelevant to the health equity agenda advanced by the WHO Commission; they are actively destructive of that agenda and its commitment to social justice. If such initiatives cannot be reinvented quickly and comprehensively, it is worth considering whether equity would be best served by shutting them down.[128]

Responding to lifestyle drift might be one of those "tough questions" that health professionals seeking to address health equity gaps must be willing to ask in order in order to "take action with the full and meaningful engagement of those most affected."[129]

A recent report by NHS Health Scotland concluded that tackling root causes, the "underlying inequalities in income, wealth and power," are likely to be the only way to sustainably achieve progress on health inequities.[130] An organizational barrier to being able to address root causes is reticent by public health units that depend on government funding to challenge the status quo.[131] A barrier to the public health workforce being able to address root causes is the potentially "career-threatening"[132] consequences of speaking out as public health professionals or even as citizens.[133] Barriers to nurses working in public health being able to slide harmoniously between their downstream and upstream work include: financial and administrative constraints;[134] "relentless public health restructuring;"[135] and movement from a population-focused practice with a strong connection to the community to "greater attention to specialization and task orientation."[136]

Nurses, like other members of society, are profoundly influenced by the social, economic, political, and cultural contexts in which they live. Peace researcher, Johan Galtung, has defined structural violence as

any constraint on human potential due to economic and political structures. Structural inequities in access to resources and political power create inequitable access to opportunities.[137] Cultural violence is any aspect of a culture that can be used to legitimize violence in its structural or direct forms.[138] Nurses, like other members of society, are not immune to exacerbating social and health inequities when blinded by the norms of cultural violence:

> Under scrutiny, one finds that the provision of nursing services to impoverished, vulnerable people has often been characterized by racial and class biases, social control agendas, superficial approaches to structural problems, naïve and ineffectual activism, and an inflated sense of the importance of nurses that distracts attention from profound systemic problems.[139]

Being able to recognize patterns of structural violence and the cultural violence that make it seem natural are part of the challenge that registered nurses face in addressing health and social inequities as public health professionals and as citizens.

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