National Collaborating Centre
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KEYWORDS IN HEALTHY PUBLIC POLICY

REPORT | MARCH 2014

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ABOUT THE NATIONAL COLLABORATING CENTRE FOR HEALTHY PUBLIC POLICY

The National Collaborating Centre for Healthy Public Policy (NCCHPP) seeks to increase the expertise of public health actors across Canada in healthy public policy through the development, sharing and use of knowledge. The NCCHPP is one of six Centres financed by the Public Health Agency of Canada. The six Centres form a network across Canada, each hosted by a different institution and each focusing on a specific topic linked to public health. In addition to the Centres' individual contributions, the network of Collaborating Centres provides focal points for the exchange and common production of knowledge relating to these topics.

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INTRODUCTION

Expressions such as *public policy*, *the social determinants of health*, and *population health* are so common in public health discourse that we often use them without thinking about what they mean, much less about how they have come to acquire their current meanings and what the implications of their use(s) might be for the way that public health work is discussed and carried out. Their common use means that we often assume we are talking about the same thing when in fact two people using the same term might have completely different things in mind. In using the expression *the social determinants of health*, for example, some might think about a specific set of determinants (gender, income, education, housing, etc.), while others might think about the processes which determine the distribution of health outcomes in a population. In what follows, we take the meanings of commonly-used expressions in healthy public policy work and attempt to highlight how they are used within public health discourse.

Our goal in this document is to explore the life and resonance of three expressions that are important in our public policy. Each of these is variously defined, and these definitions have evolved over time. We will take a broad look at them, following the notion of *keywords* developed by Raymond Williams (1975) and later expanded by Bennett, Grossberg, and Morris (2005) in the context of studies on culture and society. Where applicable, we will point to further reading for additional resources and current definitions. However, we will not attempt to pin down a single definition for any of the keywords; indeed, given the polyvalence of these terms, single definitions do not readily present themselves. Rather, our goal is to examine the whole neighbourhood of a word, to look around and get to know what it is like and how it has come to look like this; this is a very different exercise than providing directions to a single address.

In these sections, we concern ourselves with how these expressions have come to have one meaning in some cases and different meanings in different traditions and at different times. Often a word used commonly in a language can mean something different in specialized discourse. Even within specific fields, different theoretical traditions can use the same words in quite different ways. The word *gender*, for example, is used quite differently in the social sciences than in popular discourse (where it often simply replaces the word *sex*), and within gender studies itself, the concept has evolved to encompass more range and variability than it did just a few decades ago.

Our goal in the sections below is to explore how these concepts and expressions have been developed, understood and used. The point is not to argue for or against one or even several definitions, but to explore the various definitions, explicit or not, that are currently in circulation. We hope that by attempting to clarify these conceptually rich terms, we might avoid some recurrent problems that are associated with their common usage, conceptual depth and diversity. First, becoming more familiar with them might make it easier to identify how others are using these expressions in practical settings; this might in turn help to reveal whether or not people are indeed speaking the same language. Then, if it turns out that the expressions in question are not being used in the same way, this familiarity will increase the likelihood of finding common ground. In addition, becoming familiar with the nuances in these terms might help to make connections between concepts.

Each keyword/section contains a list of related concepts, that is, other keywords that are commonly used in conjunction with or alongside that keyword. We provide a brief description of commonly used definitions for the term and go on to explore its origins. Following that, we explore the ways that the keyword has been deployed in public health literature and finally, where it exists, we note major criticisms that have been voiced.

We hope that this tour of these three expressions proves helpful and interesting for you. We welcome your feedback as well as suggestions for other terms to add to this collection.

1 KEYWORD: POPULATION HEALTH

Related concepts:[1] (Social) determinants of health, health inequalities/inequities, public health, health promotion, population health promotion, McKeown thesis, the new public health, health production function

Population health has come to be favoured as an approach to public health in Canada after becoming a central term in the mid-1990s, when it was picked up and developed by researchers and policy makers. It follows in a long line of theoretical developments from the McKeown thesis (Colgrove, 2002), through the 1974 Lalonde Report (Lalonde, 1974), the World Health Organization's 1986 Ottawa Charter (World Health Organization [WHO], 1986), and other key works such as Geoffrey Rose's population strategy (Rose, 1993) in having as its primary focus the prevention of disease rather than its treatment. Population health is also intricately tied to a focus on the social determinants of health and on intervention at the level of these determinants rather than on subsequently developing diseases and conditions. This section begins with an outline of the origins of the term *population health*, goes on to look at the three primary ways in which it has been and is used in Canada, and concludes with a brief presentation of the major debates and criticisms of the term and its origins.

1.1 ORIGINS

The term *population health* was first published[2] in an article by Evans and Stoddart in 1990 (Evans & Stoddart, 1990). Most of the early work on population health was produced by the Canadian Institute for Advanced Research (CIAR), specifically its Program in Population Health, a program that was created in 1987 and funded in large part by a grant from Manufacturer's Life Insurance Company of Canada. Disciplinarily, the term *population health* is grounded in epidemiology, to which economics was grafted. Politically, it evolved in a climate of increasing pressure to reduce health care costs and increase the financial accountability of the health care system in Canada. In this sense, the increasing evidence of the role of the nonmedical determinants of health was combined with a perceived need to curb ever-rising health care costs. Clearly, not all work on the nonmedical determinants of health and subsequently on population health is tied to the CIAR group, but the influence of this group's members and positions in public health and in policy circles has made it *the* central figure in the development of population health in Canada.[3]

1.2 THE USES OF POPULATION HEALTH

The term *population health* has been used in Canada in three main ways: as a concept, as a framework for analysis and intervention, and as a broad approach.

[1] Related concepts are those that are commonly linked to the keyword in the literature.

[2] The term had been used by Fraser Mustard and others in a series of lectures in a graduate seminar in Health Sciences at McMaster University in 1983 (Hayes & Dunn, 1998).

[3] This influence has extended beyond Canadian borders owing in part to the solid reputation of Canada in health promotion.

Population health: the concept

As a concept, *population health* refers in short to the health of populations, however those populations are defined. In this sense, it is usually used in an operational fashion as part of a research program or project. One such project defines population health as "the health outcomes of groups of individuals, including the distribution of such outcomes within the group" (Kindig & Stoddart, 2003, p. 381). This kind of definition continues to be used as a very basic one even when researchers assert that population health is an approach or a framework. At its most basic, population health is distinguished from health care by its focus on whole populations; traditional health care focuses on individuals, one at a time.

Population health: the framework

The first accounts of the *population health framework* came from authors working within the CIAR (Evans & Stoddart, 1990). The CIAR work stimulated a move beyond a static concept of population health to an overarching framework for analysis and intervention. It is within such frameworks that the integration of the role played by the nonmedical determinants of health is inextricably connected to the notion of population health. In this work, and particularly in the framework proposed by Kindig & Stoddart (2003, p. 382), the concept of population health is viewed as only one of three elements necessary for a population health framework. The two additional components included in most of the literature that adopt this framework include 1) a focus on the nonmedical determinants of health, and 2) the need for intersectoral or collaborative efforts to address population health. It is worth noting that the CIAR work has an explicit focus on curbing health care system spending and many of the group's members assert that focus as justification for adopting this framework. A federal/provincial/territorial advisory report, which has been officially adopted in Canada, lists this cost savings as the first "main requirement and implication" of adopting this framework (Health Canada, 1994, p. 33). As an overall framework, population health addresses the nonmedical determinants of health as well as strategies for public health and policy intervention.

Population health: the broad approach

Finally, *population health* is increasingly used to refer to a strategic program for public health departments and organizations. In this sense, population health is often uncritically accepted as an approach to public health that focuses on the role of nonmedical determinants and involves programmatic intervention on these. This may be the case with local and regional health authorities, which may say they use a population health approach and may or may not state what is included in this approach. In these cases, it is generally not the desire of the organizations to further the concept or the framework for analysis and intervention, but to practically apply the core principles of population health as they understand them.

1.3 CRITICISMS AND DEBATE

Although population health has clearly risen to become the dominant approach to public health in Canada (at least theoretically), it has not been without its critics. Many have asserted that the population health framework and approach are too rooted in the scientific traditions of epidemiology to successfully integrate perspectives from other disciplines and traditions (Coburn et al., 2003). Notably, some critics argue that "the CIAR methodology did

not readily embrace practices from the social sciences," including the use of "contemporary social theory, ... objectivity/subjectivity position of research as action, development of notions of power, identity, gender, communication, or analysis of labour or land markets, the space economy, and so forth" (Hayes & Dunn, 1998, p. 9). Others have suggested that CIAR scholars' argument that a general focus on wealth creation would address population health as a corollary effect leads to context-stripping and an oversimplified equation of wealth and health (Poland, Coburn, Robertson, & Eakin, 1998). Still others have focused on the close ties between population health and health care cost-cutting and the consequent move away from the social justice and values-oriented approach associated with the health promotion tradition cemented by the 1986 Ottawa Charter (Raphael, 2002). These critiques note that embracing a population health approach is inconsistent with equity-focused public health and takes away from the fight against health inequalities. However, those organizations and agencies that do explicitly embrace a population health approach most often also emphasize the reduction of health inequalities as part of their mandates.

Population health has evolved to become the central approach to public health in Canada over the past two decades. As it is embraced by a growing number of public health agencies and organizations, there is now less work that seeks to refine population health as a concept or as a framework and more that seeks to put the population health approach into practice and policy.

2 KEYWORD: SOCIAL DETERMINANTS OF HEALTH

Related concepts: Health disparities/inequalities/inequities, population health, health promotion, social gradient in health, healthy public policy, intersectoral action, health in all policies

Although both the *determinants of health* (DOH) and the *social determinants of health* (SDOH) have become quite common terms in public health work in Canada, there is no consensus on the difference between the two. For some, DOH is a broader term which includes SDOH, while for others, SDOH includes everything from genetic predisposition to underlying political structures. While noting this disparity of use, in this section we will mainly focus on the SDOH, as this term appears to be the most commonly used and is most closely aligned with healthy public policy discussions. Moreover, the World Health Organization's landmark Commission on Social Determinants of Health (2005-2008) refers specifically to these factors and their interplay as the social determinants of health:

> The social determinants of health are the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics (WHO, 2013).

By the early 2000s, approaching public health through the lens of its social determinants had become dominant in the literature in Canada. While the translation of this approach into front line public health activities is not uniform, by now, most public health authorities have incorporated this perspective into their missions. Here we trace some of the origins and uses of the term and address concerns raised by some critics of the concept and its application in public health.

2.1 ORIGINS

Although the terms *factors*, *influences,* and *contributions* were more commonly used in the 1970s and 1980s, approaches based on the social determinants of health can be dated to this period with the successive publication of, among others, the Lalonde Report (Lalonde, 1974), the Alma-Ata Declaration (WHO, 1978), the Black Report (Working Group on Inequalities in Health, 1980) in the United Kingdom, the Ottawa Charter (WHO, 1986), and the Epp Report (Epp, 1986). Each of these documents makes the case that health is largely a result of factors outside of the health care system — notably, of the conditions in which people live and work — and that the goal is thus to create healthy environments through public policies from many different sectors, including, but not limited to, the health sector.

Since the 1990s, work on the SDOH has increased at a steady pace and approaches and frameworks have developed considerable depth. Less clear are the precise determinants themselves and the best approaches within public health and public policy to address these.

2.2 THE USES OF SOCIAL DETERMINANTS OF HEALTH

There are two main approaches to defining the social determinants of health and how they operate. These might be called: the list approach and the conceptual framework approach. While the former pays most attention to identifying the singular social factors that contribute to health outcomes, the latter is concerned as much with how these determinants act as with what they are.

Social determinants of health: the list approach

Many lists of the social determinants of health (and of the determinants of health) can be found in the literature. In the Appendix, we include a comparative table of five of these lists developed in Canada, and show where the lists are similar and where they are different. Five determinants are common to all of these lists: income and social status, education, employment and working conditions, early childhood development, and health services. While there is some convergence, there is also divergence among the elements on many of the lists. For some, the lists are confusing, as they refer to vastly different phenomena. (For example, some are ascribed statuses, some refer to determinants that are achieved, and others refer to government services or to stages in the life cycle.) This has led some researchers to move away from simple lists of determinants and to attempt to design conceptual frameworks of levels of determinants and their relative importance.

Social determinants of health: the conceptual framework approach

Conceptual frameworks for SDOH, such as the early one developed by Dahlgren and Whitehead in 1991, shown below, represent attempts to understand the different levels at which social determinants operate and the levels at which policy interventions might be made.

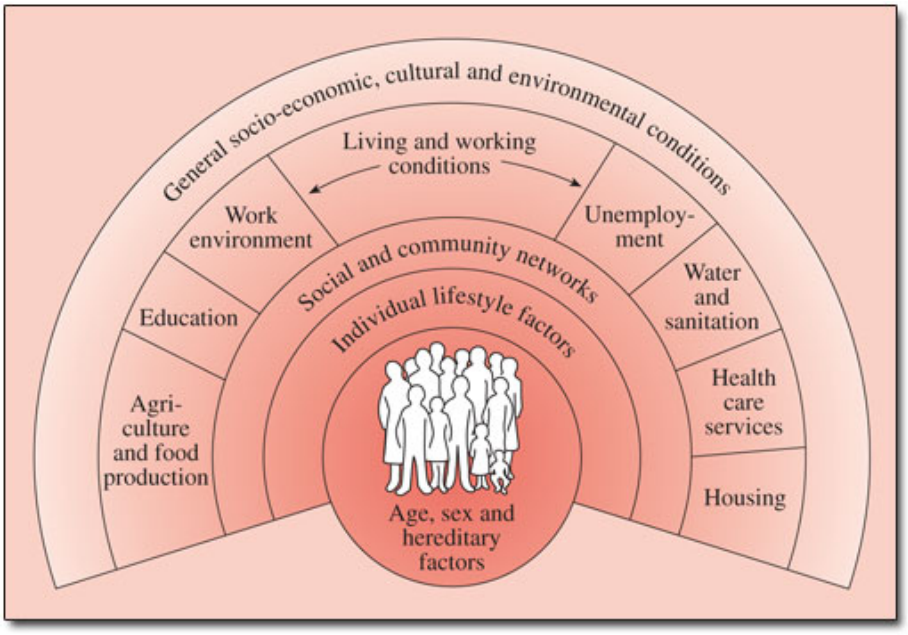

Figure 1 Conceptual framework for social determinants of health (Dahlgren & Whitehead, 1991, p. 11)

While this and other such frameworks represent a move away from the list approach, they do not explicitly theorize *how* the determinants operate. Much of the work on the SDOH culminated in the World Health Organization's Commission on Social Determinants of Health (2005-2008), which is one of the most comprehensive attempts to date to understand not just what the social determinants of health are but also how they operate and how they influence each other. The figure below presents the conceptual framework developed during the course of the commission.

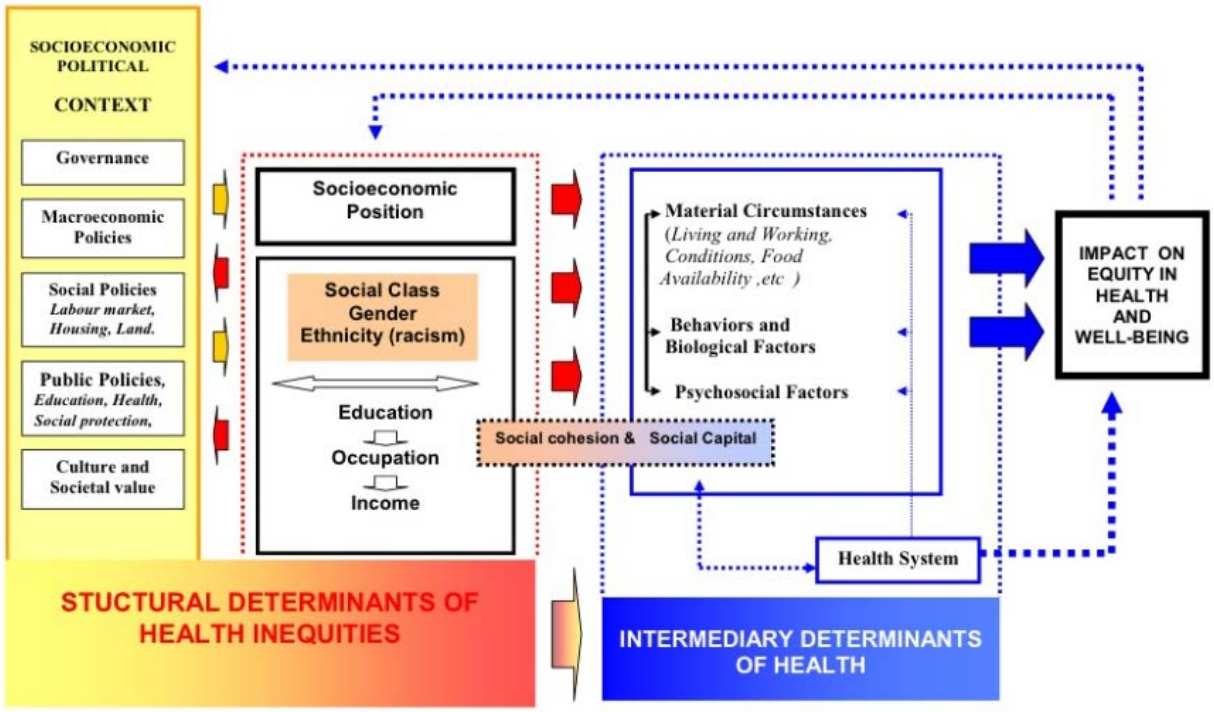

Figure 2 Conceptual framework for action on the social determinants of health (Commission on Social Determinants of Health, 2007, p. 48)

This framework makes a clear distinction between the structural determinants of health inequities and the intermediary determinants of health.[4] This represents a significant break from other approaches, where macro social policies tend to be listed alongside social and individual characteristics. Here, broad social policies and ideologies are portrayed as the first instances in determining population health. Moreover, material circumstances (such as housing, working conditions, and food security) are explicitly positioned as intermediary determinants and thus, as the outcome of structural determinants. This framework attempts not only to list the major determinants of health, but significantly shows the interplay between them and how they influence each other.

[4] The distinction between determinants of health and determinants of health inequities is crucial and is only mentioned in passing in this document.

2.3 POLICY INTERVENTIONS

Much of the writing on the SDOH includes general guidelines and suggestions for program and policy interventions. While most propose broad policy and program directions, some of the list approaches divide their program and policy suggestions (when these are included) into lists, based on their lists of the determinants. Moreover, most include interventions at both the upstream and downstream levels. The WHO commission included a conceptual framework for policy intervention that, like its conception of the SDOH, attempts a broad view of the components necessary for intervening on the SDOH:

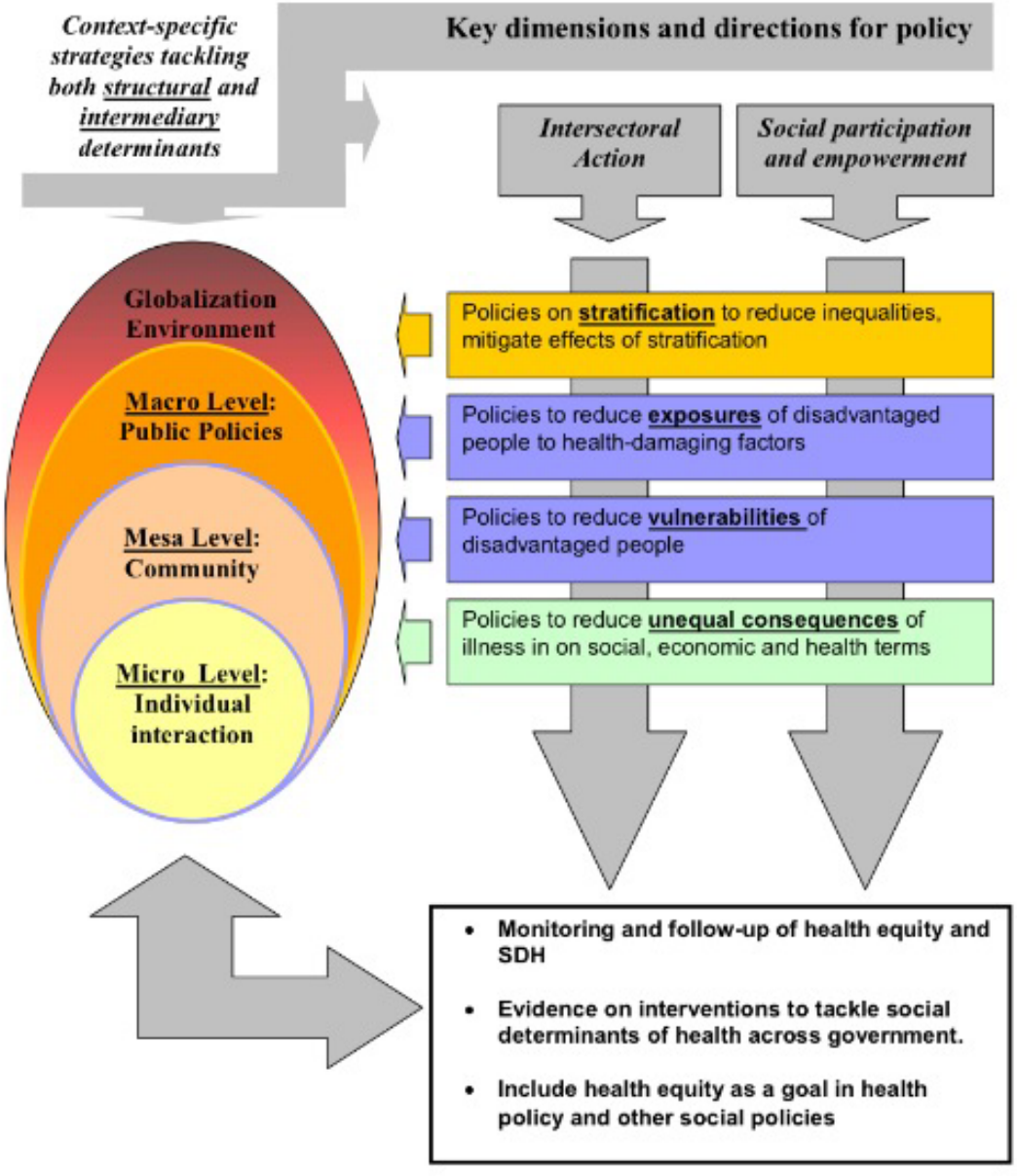

Figure 3 Framework for action on tackling social determinants of health inequities (Commission on Social Determinants of Health, 2007, p. 62)

The WHO designed this as a comprehensive and quick guide to the most promising policy approaches to strategies that tackle both the structural determinants of health inequities and the intermediate determinants of health. The key dimensions here are along the top. Policies are context specific and address both the structural and intermediary determinants by favouring both intersectoral action and social participation and empowerment. The four broad policy types can be applied at all of the levels on the left. Tellingly, these levels are represented as overlapping ovals: policies at the central (macro) level need to be coherent as they move to the core of each oval. The four specific types of policies are all general enough that they can be used as guidelines for broad or very narrow, targeted policies; they comprise the most promising and important policy types for intervening on the SDOH:

1. Policies on stratification to reduce inequalities and mitigate the effects of stratification: examples include policies on wealth redistribution, labour market policies that favour adequate work and pay, or a variety of widely accessible government services (education, health care, etc.).
2. Policies to reduce exposures of disadvantaged people to health-damaging factors: policies of this sort include things like subsidized housing for low-income families and programs aimed at making neighbourhoods safer.
3. Policies to reduce vulnerabilities of disadvantaged people: these include unemployment insurance, old age security pensions, and school lunch programs for children from low-income families, for instance.
4. Policies to reduce unequal consequences of illness in social, economic and health terms: policies of this sort include income supplements in times of ill health and policies that encourage retaining people with chronic illnesses in the work force, for example.

Each of these policy types can be approached from the micro to the global levels by favouring each level in context and addressing structural and intermediary determinants through intersectoral action that promotes social participation and empowerment.

2.4 CRITICISMS AND DEBATES

One of the major criticisms of the social determinants of health approach found in the literature is that, while it is at the forefront of writing about public health in Canada, it is much less prominent in practice (Low & Thériault, 2008; Raphael, 2003). Many of those critical of the population health approach outlined above are critical of the social determinants of health approaches for similar reasons. These include the argument that population health literature incorporates much from epidemiology and related disciplines and less from the social sciences, making concepts such as the social determinants of health under-theorized (Hayes & Dunn, 1998; Coburn et al., 2003). Documentation within public health practice indicates that there may be a lack of clear understanding of SDOH on the front lines of public health intervention. Sudbury & District Health Unit (Sudbury District and Health Unit, 2009), for example, noted in implementing its equity strategy that there were differences in the ways that their team members understood the determinants and the levels at which they operate.

Many public health interventions continue to focus on changing individual behaviours and lifestyle factors rather than intervening on structural determinants. Several reasons might explain this disparity in orientation and practice. First, work on structural determinants of

health inequities can face obstacles, particularly as most of this work is necessarily out of the direct jurisdiction of public health. Moreover, some of the writings on the social determinants make general recommendations without specifying how public health may contribute. For example, writers may mention intersectoral action and public policy advocacy without adequately specifying how public health practitioners can fulfill these new roles.

Social determinants of health approaches to public health in Canada have become central over the past two decades. While many, if not most, public health authorities include the SDOH approach as part of their mandates and/or missions, disparity remains between the types of approaches embraced (lists vs. conceptual frameworks) and between theory and practice.

3 KEYWORD: PUBLIC POLICY

Related concepts: Government, governance, state, healthy public policy, public health

3.1 THE USES OF PUBLIC POLICY

While there are many varied applications of the concept of public policy, the two main applications are those described here: policy statement and public action. To begin, however, it is worth noting that the term is often used in an abridged form: the *public* qualifier is often left out, even though its presence makes the exclusion of *private* policies, such as those governing the activities of an organization, more explicit.

Policy statement

Milio uses the concept of public policy to mean *policy statement* when she explains that policy " is a guide to action to change what would otherwise occur, a decision about amounts and allocations of resources […] the distribution of the amount shows the priorities of decision makers" (Milio, 2001, p. 622). Inherent in this usage is the notion that public policy directs or guides the actions or decisions of public or private stakeholders authorized to act on behalf of the public good. An implicit assumption of this usage is that public policy is something easily definable and with clear parameters, as for example, the City of Montréal's tree policy (City of Montréal, 2005).

The policy statement is frequently used by bureaucracies to give meaning to public action, to structure actions taken and decisions made by identifying objectives and selecting criteria and principles for actions that will enable these objectives to be met. Policy statements are often distinguished from strategies, action plans, programs, measures, interventions, and so forth.

A hierarchy is often established between these diverse elements: a policy would precede and inform the strategies, which would themselves inform action plans, and so on.

A policy statement sometimes forms part of an effort to appreciate or evaluate the effectiveness of public action to meet certain goals. For example, the Québec government has a waste management policy, which it can use to assess the waste management efforts deployed by both the government and the organizations identified by this policy (Ministry of sustainable development, environment, wildlife and parks, 2011). Another example is the New Brunswick Department of Education's Policy 711, which "establishes the minimum requirements for healthy foods in [the province's] public schools" (Government of New Brunswick, 2008, p. 1).

In academic circles, the concept is mainly used this way by researchers involved in policy adoption or implementation processes. For example, researchers at the *Groupe d'étude sur les politiques publiques et la santé* (a Québec study group on public policy and health) used the policy statement definition, in order to try to understand the adoption of the Québec government's continuing education policy (Gagnon, Michaud, & Garant, 2007).

Public action

When the concept of public policy is used to mean *public action*, it refers to a set of actions by public authorities intended to act on events that are defined as being problematic. For example, sociologists argue that “to speak of public policy is to identify the action taken by a public authority (alone or in partnership) to handle a situation perceived as being problematic... Public policies are collective actions that participate in the creation of social and political order” (Lascoumes & LeGalès, 2006, p. 5, translation).

Reality, thus objectified, is definitely less easily defined than in the case of the policy statement application, since public action deals with a reality that is most often composed of diverse elements (such as laws, regulations, plans, strategies, instruments, and physical, cognitive, and normative devices), which are changeable. For example, public action regarding the movement of people and goods includes not only a variety of laws and regulations but also taxes, research and development projects modelling traffic flows or other parameters, road improvements, and so forth. However, all these elements change over time (laws concerning drinking and driving may be enacted or modified, highway tolls may be removed or introduced, and so on), making public action a motley assemblage under constant reorganization.

In government, public action is almost always used in the context of dynamic practices associated with specific strategic objectives. In shaping healthy public policies, for example, it is important to understand the processes that drive public actions in order to identify effective interventions (see Fafard, 2008, for example).

The desire to fully understand public actions in order to intervene strategically can also be found at times in academic research work. However, this is not always very significant or explicit. Academic researchers tend to be stimulated more or less exclusively by theoretical concerns in their analyses of the processes that drive public actions or their effects. This is true in the study of agenda development as well as in applied sciences, the sociology of public action, and other areas.

CONCLUSION

As we can see from the three concepts discussed above, there is a great deal of depth and variety to be found within keywords in common use in public health. How we approach them can affect what we mean.

Our goal in taking a keywords approach to these concepts is, as we said at the outset, to clarify them. First, we want to briefly introduce the range and depth of these common expressions in order to make them more accessible, particularly for readers who work in public health and use these terms in everyday discussions with colleagues. Having a sense of the range of meanings and the origins of these terms might help people to communicate, plan, and work in greater harmony.

Second, when we reflect on some of the broad social aims of public health, it is clear that working multisectorally is an essential part of work for many if not all public health actors. For those who wish to advance population health objectives and contribute to developing healthy public policies, these aims will oblige us to communicate and work *within* public health but also *outside* it with other sectors such as education, urban planning, and social work. In addition, we may also work with decision makers, community developers, not-for-profit organizations, various levels of government, and others. Toward this end, a keywords approach helps us to be aware of the importance of the expressions we use; conceptual clarity becomes even more necessary as we cross sectoral boundaries and work at different levels or with different groups. How, for example, do those in other sectors of society talk about the social determinants of health? We can be sure that some of the same underlying considerations are important there, but they may be addressed or conceptualized quite differently. We may have to think about our language and the concepts we use to ensure that we can find the common ground in language that will help us see our common social goals and work together toward advancing them.

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APPENDIX – EXAMPLES OF LISTS OF DETERMINANTS DEVELOPED IN CANADA

Examples of lists of determinants developed in Canada

Note: Terms presented in the table and footnotes are those used in the documents discussed.

	PHAC (2011)	Mikonnen & Raphael (2010)	Senate subcommittee on Population Health (2009)	Chief Public Health Officer (2008)	Conference Board of Canada (2008)
Focus	*DOH*	*SDOH*	*DOH*	*SDOH*	*SDOH*
Income and social status	X	X[1]	X	X	X
Education and literacy	X	X	X	X	X
Employment and working conditions	X	X[2]	X	X	X
Social support networks	X		(X)[3]	X[4]	X
Social environments	X	X[5]	(X)[3]		
Food security		X		X	X
Physical environments	X		X	X	X
Housing		X	X	X[6]	X[6]
Personal health practices	X[7]		(X)[3]	X	X
Early childhood development	X	X	X	X	X
Biology and genetic endowment	X		X		
Health services	X	X	X	X	X
Social safety net		X			
Gender	X	X	X		
Culture/Race/Aboriginal status	X	X[8]	X		X[9]
Disability		X			

1. "and income distribution across the population."
2. This report lists "Unemployment and job security" as a distinct SDOH (whereas other lists merge all factors related to employment into one single SDOH).
3. Presented as a determinant in chart 1 on page 6 of the report but not discussed further in the text.
4. The way this report frames this SDOH includes elements related to social environments, such as social exclusion.
5. Framed as "Social exclusion."
6. "Environment and housing."
7. "and coping skills."
8. The concept of 'culture' is framed as "Aboriginal status" and "Race."
9. The concept of 'culture' is framed as "Aboriginal status."

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