The health of Canada's children. Part III: Public policy and the social determinants of children's health

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The health of Canada's children does not compare well with other wealthy industrialized nations. Significant inequalities in health exist among Canadian children, and many of these inequalities are due to variations in Canadian children's life circumstances – the social determinants of health. The present article describes the social determinants of children's health and explains how the quality of these social determinants is shaped, in large part, by public policy decisions. The specific public policies that shape the quality of Canadian children's health are examined, and Canadian approaches in comparison with other wealthy developed nations are described. Policy directions that would improve the quality of the social determinants of children's health are presented and barriers to their implementation are considered.

Key Words: *Public policy; Social determinants; Social paediatrics*

La santé des enfants canadiens. Partie III : Les politiques publiques et les déterminants sociaux de la santé des enfants

La santé des enfants canadiens ne tient pas la comparaison par rapport à celle des autres riches pays industrialisés. On remarque des écarts de santé importants entre les enfants canadiens, et bon nombre de ces écarts sont imputables aux variations de leur situation de vie, c'est-à-dire les déterminants sociaux de la santé. Le présent article décrit les déterminants sociaux de la santé des enfants et expose en quoi leur qualité dépend largement des décisions en matière de politiques publiques. L'auteur examine les politiques publiques qui façonnent la qualité de la santé des enfants canadiens et décrit les approches canadiennes par rapport à celles d'autres riches pays industrialisés. Il présente les orientations gouvernementales qui amélioreraient la qualité des déterminants sociaux de la santé des enfants et examine les obstacles à leur mise en œuvre.

Part I of the present series provided key indicators of Canadian children's health and identified health inequalities among Canadian children. When placed in comparative perspective, Canada's performance in relation to other wealthy industrialized nations was seen as mediocre at best. Part II described mechanisms and pathways that shape health outcomes. Living circumstances set children on health-related pathways. Childhood living circumstances have immediate effects on children's health and also contribute to their health status as adults.

In the present article, children's living circumstances are placed within a social determinants of health perspective. Various social determinants of children's health are outlined. The specific public policies that shape the quality of health determinants are examined, and Canada's approach is compared with those of other wealthy developed nations. Various policies that would improve the quality of the social determinants of children's health – thereby improving children's health – are presented. Significant barriers to implementing these policies are considered.

THE SOCIAL DETERMINANTS OF CHILDREN'S HEALTH

The idea that living circumstances shape health is not new. The concept first appeared with Plato in the fourth century BC and was later restated by Virchow and Engels in the mid-19th century (1). The publication of the Black Report in the United Kingdom rekindled interest in these issues during the 1980s, and the term 'social determinants of health' emerged as a means of describing the important living circumstances that shape adults' health. The term has since been applied to children's health, and 'early childhood development' is itself commonly designated as a social determinant of health (2).

The social determinants of health concept explicitly considers how children and their parents' living circumstances shape children's health (3). Various formulations of the social determinants of health share a concern with societal risk conditions rather than personal risk factors (Table 1). Because the quality and distribution of social determinants of health are shaped by public policy decisions, the Social Determinants of Health National Conference list is especially useful; it specifically focuses on the public policy environment (eg, income and its distribution) rather than characteristics associated with individuals (eg, income and social status) (4).

Social determinants are important for children's health in two main ways. First, poor-quality social determinants directly threaten children's health. The social determinants that best exemplify these processes are food insecurity, poor-quality housing and lack of responsive health care services. Aboriginal status and income are important social determinants of children's health because they influence the extent of food security, and quality of housing and health care services that children experience.

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TABLE 1
Various conceptualizations of the social determinants of health

Ottawa Charter for Health Promotion (30)	Peace, shelter, education, food, income, stable ecosystem, sustainable resources, social justice and equity
Dahlgren and Whitehead (31)	Agriculture and food production, education, work environment, unemployment, water and sanitation, health care services and housing
Health Canada (32)	Income and social status, social support networks, education, employment and working conditions, physical and social environments, healthy child development, health services, sex and culture
World Health Organization (33)	Social (class health) gradient, stress, early life, social exclusion, work, unemployment, social support, addiction, food and transport
Centers for Disease Control and Prevention (34)	Socioeconomic status, transportation, housing, access to services, discrimination by social grouping (eg, race, sex or class), and social or environmental stressors
Social Determinants of Health National Conference (3)	Aboriginal status, early life, education, employment and working conditions, food security, sex, health care services, housing, income and its distribution, social safety net, social exclusion, unemployment and employment security

Second, social determinants of health influence the ability of parents to support, stimulate and nurture their children's intellectual, emotional and social development (5). Social determinants of health experienced by parents that influence their children's health include parental education, employment and working conditions, social safety net, social exclusion, and unemployment and employment security.

PUBLIC POLICY AND THE SOCIAL DETERMINANTS OF HEALTH

Despite growing acceptance of the importance of the social determinants of children's health, the explicit link between social determinants and public policy-making is sometimes neglected (6). For example, reports frequently identify income as a social determinant of children's health, but the need for governments to raise minimum wages or increase social assistance payments to health-sustaining levels may be downplayed (see addendum) (7).

Governmental authorities shape children's living circumstances by influencing how income is distributed and determining the availability of affordable housing and early childhood education and care. Governments shape parents' employment security and working conditions through legislation and regulation. Nations, regions and cities differ in how these issues are approached, with resultant health outcomes; historical analysis reveals that governments also go through periods of greater or lesser attention to social determinants of health-related issues (8).

Table 2 presents examples of how public policy influences the quality of the social determinants of children's health. It should be noted that in many social determinant of health-related policy domains – eg, income inequality, employment, housing and food insecurity, etc – Canada lags behind most wealthy industrialized nations (9,10). This has not always been the case; Canadian public policy during the 1970s showed many similarities with the Swedish welfare state (11).

TABLE 2
Social determinants of health and their public policy antecedents

Early life	Wages that provide adequate income inside the workforce, or assistance that does so for those unable to work, affordable quality childcare and early education, affordable housing options, and responsive social and health services
Education	Support for adult literacy initiatives, adequate public education spending, tuition policy that improves access to postsecondary education
Employment and working conditions	Training and retraining programs (active labour policy), support for collective bargaining, enforcing labour legislation and workplace regulations, increasing worker input into workplace environments
Food security	Developing adequate income and poverty-reduction policies, promoting healthy food policy, providing affordable housing and affordable child care
Health services	Managing resources more effectively, providing integrated, comprehensive, accessible, responsive and timely care
Housing	Providing adequate income and affordable housing, reasonable rental controls and housing supplements, providing social housing for those in need
Income and its distribution	Fair taxation policy, adequate minimum wages, and social assistance levels that support health, facilitating collective bargaining
Social exclusion	Developing and enforcing antidiscrimination laws, providing ESL and job training, approving foreign credentials, supporting a variety of other health determinants for newcomers to Canada
Social safety net	Providing economic and program supports to families and citizens comparable with those provided in other wealthy developed nations
Unemployment and job insecurity	Strengthening active labour policy, providing adequate replacement benefits, provisions for part-time benefits and advancement into secure employment

ESL English as a second language

Consider the social determinant of health most relevant to children – early child development. There are two sets of public policy domains that influence early child development.

The first public policy domain is concerned with the provision of economic security. Early development is shaped by the availability of sufficient material resources that assure adequate nutrition and housing, and cognitive and emotionally supportive family environments among others. Much of this domain has to do with parents' employment situation and wages, the availability of affordable housing, educational and recreational opportunities, and if necessary, retraining opportunities and social assistance. Child poverty rate is an excellent overall indicator of these policy activities. Canada ranks poorly (20th of 30) among Organisation for Economic Co-operation and Development (OECD) nations in child poverty rates (14).

The second public policy domain is specifically oriented to families with children. Known as family policies, these include availability of quality early child education and care, family-friendly leave provisions, and program support and financial transfers to families. The availability of quality, regulated child care is an excellent indicator of these forms of policy activities.

PLACING THESE ISSUES IN COMPARATIVE PERSPECTIVE

There is much to gain – eg, assessing Canadian performance and identifying policy options – by examining how Canada fares in addressing these issues compared with other wealthy industrialized nations. Two approaches inform this analysis. The first compares Canadian public policy approaches to other wealthy developed nations. The second places the Canadian approach in the broad context of varying forms of political economies.

Societal commitments to families and governmental spending

All wealthy developed nations have market economies, but governing authorities can choose to distribute national wealth more equitably among the population through provision of cash benefits or benefits in kind. One key set of indicators of public commitment to supporting citizens is percentage of gross domestic product (GDP) transferred to citizens through programs, services or cash benefits.

The OECD – consisting of member states of 30 wealthy industrialized nations – regularly provides indicators of government operations including provision of supports and services (www.oecd.org). An especially important indicator is the extent of government transfers to households. Transfers refer to governments taking fiscal resources that are generated by the economy and distributing them to the population as services, monetary supports or investments in social infrastructure. Such infrastructure includes education, employment training, social assistance or welfare payments, family supports, pensions, health and social services, and other benefits.

Average public expenditures

Average OECD public expenditure – which includes social expenditures – in 2003 was 23.5% of the GDP (12). There is a rather large variation among countries, with Sweden (spending 37.1% of the GDP) and France (spending 33.1% of the GDP) being the highest public spenders. Canada ranks 18th of 24 wealthy industrialized nations (for which 2003 data are available) and spent 19.6% of the GDP on public expenditures. The only nations that allocated a smaller percentage of the GDP to public expenditure are Japan (19.1%), Slovak Republic (19%), Ireland (17.9%), the United States (17.4%), Mexico (7.6%) and Korea (6.5%).

Health care, income support and social services

How does spending translate into specific policy areas? Canada is among the highest spenders on public expenditure on health care (6.8%) and is exceeded only by Germany (8%), the United States (7.7%), France (7.6%), Belgium (7.2%), Iceland (7.2%) and Sweden (7.1%). It is in the other areas of benefits and supports to citizens that Canada reveals itself as a frugal public spender.

One way to slice up the expenditure pie is to consider spending on income support to the working-age population and social services. Income support involves family benefits, wage subsidies and child support paid by governments to help keep low-income individuals and families out of poverty. Social services include counselling, employment supports and other community services.

Canada ranks very low on income support to the working-age population and low on social services. In 2001, Canada spent just 2.8% of the GDP on income support to the working-age population (rank 27th of 30) and 2.2% on social services (rank 8th of 30). Sweden spent 7.0% on income support and 5.8% on social services, and Denmark spent 8.7% on income support and 5.4% on social services.

Active labour policy

Active labour policy refers to the extent that government supports training and other policies that foster employment and reduce unemployment. In the Nordic nations, laid-off workers are provided with employment retraining as a matter of course (13). In Canada, governing authorities usually respond to these issues in a case-by-case piecemeal manner. In 2003, Canada allocated 0.4% of the GDP to such policies. This provides Canada with a ranking of 19th of 29 wealthy industrialized nations for which data were available. The highest spenders were Denmark (1.6%), Sweden (1.3%) and Belgium (1.2%).

FAMILY POLICY

Three indicators provide a snapshot of family policy in Canada. The first indicator is the percentage of the GDP spent on family benefits, the second is public expenditure on child care and early education services, and the third is support for parental leave.

Public spending on family benefits

Figure 1 provides 2005 data on a variety of benefits provided to families in wealthy developed nations. Canada ranked 32nd of 37 nations providing data. Even the United States provided a greater proportion of the GDP to families than Canada. These findings provide much insight into why Canada was recently reported as being one of the nations showing the greatest increases in income inequality and poverty among OECD nations (14).

Public spending on child care and early childhood education services

Figure 2 provides 2005 data on wealthy nations' child care and preprimary spending. Canada scored 36th of 37 nations. Regarding public spending on family benefits, France, the Nordic nations and northern Continental nations are the highest spenders on families and children.

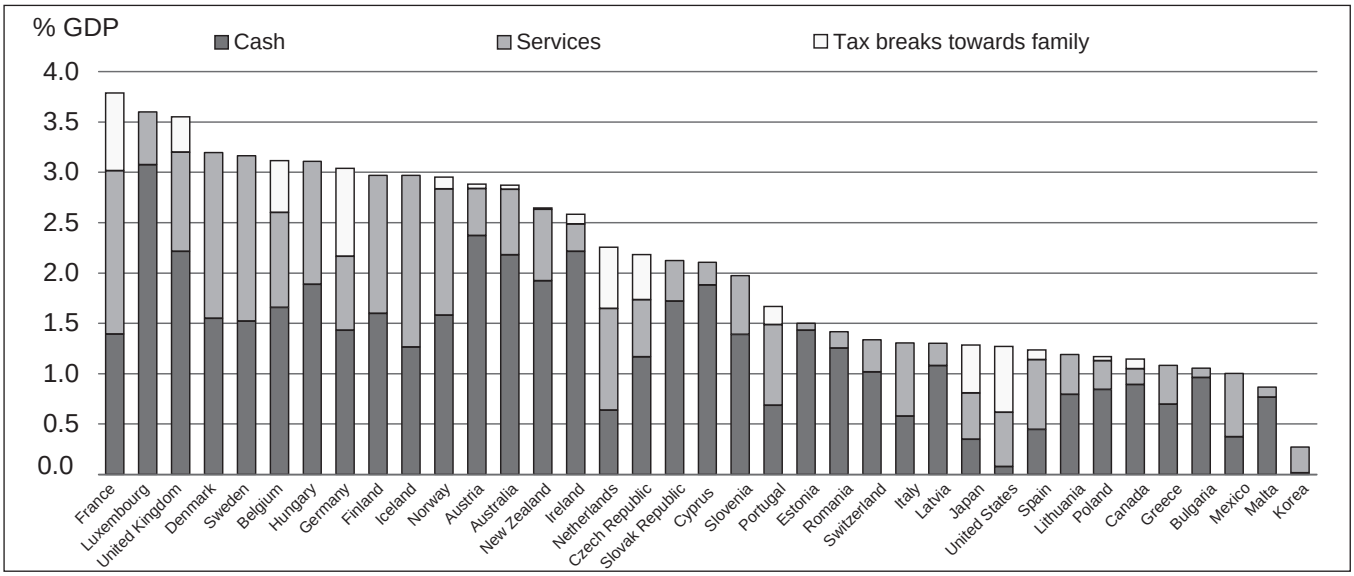

Figure 1) *Public spending on family benefits in cash, services and tax measures, in per cent of the gross domestic product (GDP), 2005. Public support accounted here only concerns public support that is exclusively for families (eg, child payments and allowances, parental leave benefits and child care support). Spending recorded in other social policy areas, such as health and housing support, also assists families, but not exclusively, and is not included here. Adapted from reference 35*

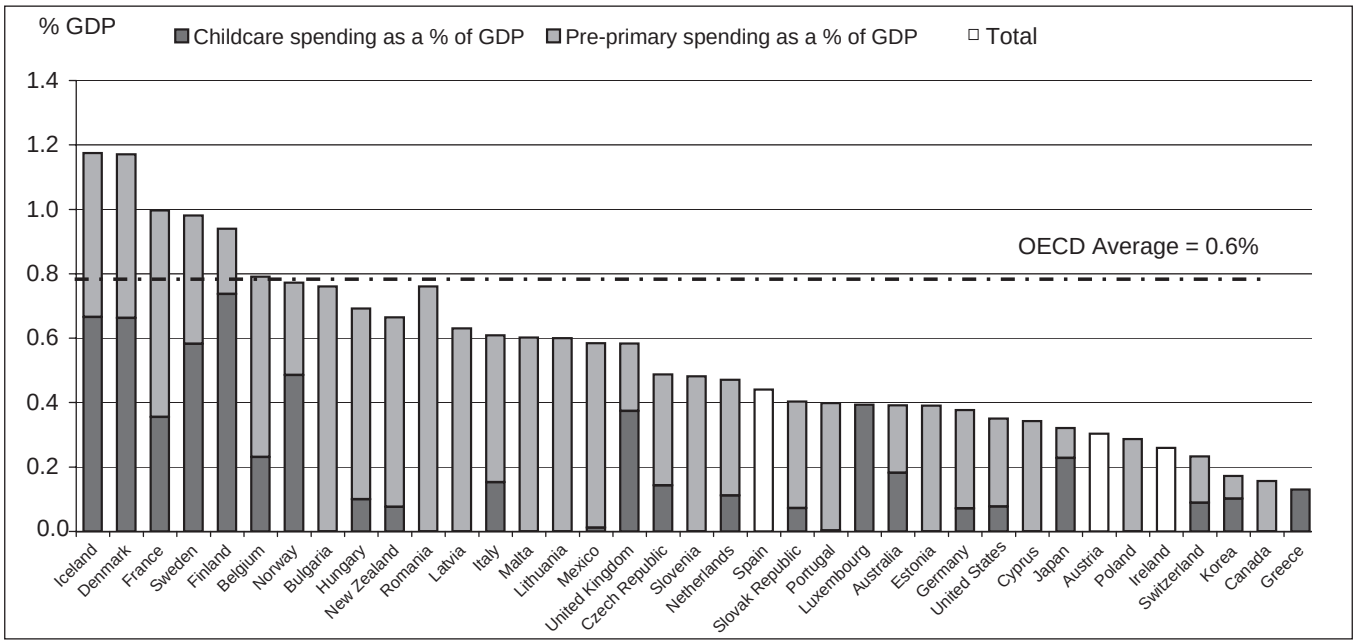

Figure 2) *Public expenditure on child care and early education services, in per cent of the gross domestic product (GDP), 2005. Bars for Austria, Ireland and Spain cannot be disaggregated by educational level. OECD Organisation for Economic Co-operation and Development. Adapted from reference 35*

Effective parental leave

A calculation that takes into account enrolment in paid maternity leave (in weeks) multiplied by per cent of usual salary paid gives Canada a ranking of 13th of 25 nations (9). France, Germany and the Nordic nations provide strong supports. The United States ranked dead last with no provision for any effective parental leave.

Chaussard et al (15) provide a detailed provincial/territorial assessment of scores on a Work Equity Canada Index. Canada as a nation lags behind other nations in terms of leave around childbearing, annual leave and sick leave. The wide variation that exists among provinces suggests areas of local advocacy activities.

A LEAGUE TABLE OF EARLY CHILDHOOD SERVICES

A recent evaluation of OECD nations' policies considered 10 benchmarks for early childhood services. These are identified as "a set of minimum standards for protecting the rights of children in their most vulnerable and formative years"

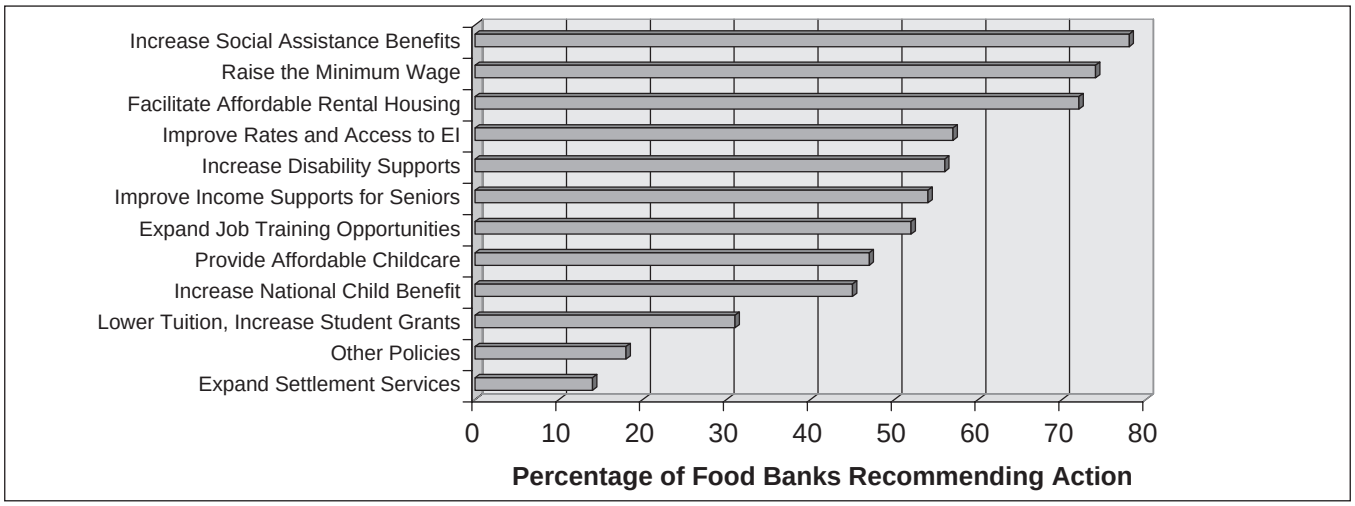

Figure 3) *Policy priorities of Canadian food banks. EI Employment insurance. Adapted from reference 21*

(9, page 2). The benchmarks are the following: parental leave of one year at 50% of salary; a national plan with priority for disadvantaged children; subsidized and regulated child care services for 25% of children younger than three years of age; subsidized and accredited early education services for 80% of four-year-olds; 80% of all child care staff trained; 50% of staff in accredited early education services tertiary educated with relevant qualification; minimum staff-to-children ratio of 1:15 in preschool education; 1.0% of the GDP spent on early childhood services; child poverty rate less than 10%; and near-universal outreach of essential child health services.

Canada received a score of 1 of 10, sharing the lowest ranking with Ireland. Canada's reached benchmark was 50% of staff in accredited early education services tertiary educated with relevant qualification. Sweden achieved a score of 10 of 10, and Iceland, Denmark, Finland, France and Norway all achieved scores of 8 of 10. The United States achieved a score of 3. The report notes that nations achieving the greatest number of benchmarks are those with the lowest infant mortality and low birth weight rates.

These profound variations among nations indicate that some choose to transfer relatively small amounts, allowing the marketplace to serve as the primary arbiter of how economic and other resources are distributed. These resources include not only wages, but whether child care, housing, and educational and recreational opportunities are made available to citizens as entitlements or as commodities to be purchased.

Governing authorities intervene in market operations through legislation that sets wages and facilitates labour organizing, ensures employment, and provides programs and benefits. It is well documented that nations that intervene are those showing lower child poverty rates and better indicators of children's health (14,16,17).

SPECIFIC POLICY AREAS FOR ACTION

Improving the quality of the social determinants of health through public policy action has health implications for Canadians – and their children – right across the socioeconomic spectrum (3,18). Besides improving the situation of the most vulnerable, well-off Canadians benefit from improved quality social determinants of health in terms of improved community quality of life, reduced social problems and improved Canadian economic performance (19,20).

TABLE 3
Campaign 2000 policy options to reduce child poverty

An enhanced child benefit for low-income families to a maximum of $5,100 (2007 dollars) per child
Restore and expand eligibility for employment insurance
Increase federal work tax credits to $2,400 per year
Establish a federal minimum wage of $10 per hour (2007 dollars)
Create a national housing plan including substantial federal funding for social housing
Establish a system of early childhood education and care that is affordable and available to all children (0 to 12 years of age)
Include a strong equity plan to ensure equal opportunities for all children and address systemic barriers
Develop appropriate poverty reduction targets, timetables and indicators for Aboriginal families, irrespective of where they live, in coordination with First Nations and urban Aboriginal communities.

Adapted from reference 22

Examples of proposals for improving the living circumstances of Canadian children come from the Canadian Association of Food Banks and Campaign 2000 (Figure 3 and Table 3) (21,22).

Not only are these recommendations similar to those of other Canadian policy organizations (23,24), they are similar to policy directions proven to be effective in improving the living circumstances of families with children in other wealthy industrialized nations (14,16,17).

A TYPOLOGY OF NATIONAL APPROACHES TO ECONOMIC SECURITY

Despite the accumulating evidence of the importance of the social determinants of health, there have been little systematic efforts by Canadian governmental decision makers to institute the profoundly successful family support approaches of the Nordic and many continental European nations (17). Given the importance of living circumstances

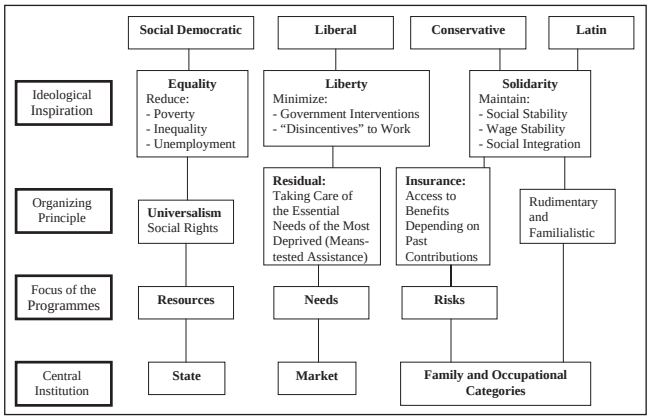

Figure 4) *Ideological variations in forms of the welfare state. Adapted from reference 25*

for children's health, the difficult circumstances many Canadian children now experience, and the available policy options for improving these conditions, why does there seem to be so little public policy activity to address these issues?

Perhaps there is something about the Canadian economic and political system that can shed light on these issues. Political economist Gosta Esping-Andersen identifies Canada, the United States and the United Kingdom as liberal political economies (25). What exactly is a liberal political economy and how does it explain the situation of Canadian children? And more importantly, what does it suggest about developing and implementing public policy in the service of children's health?

The workings of economic and political systems and their dominant values and organizing principles have been nicely organized by two Canadian sociologists (25). They provide a narrative and graphic view that succinctly sums up the roots of differing public policy approaches (Figure 4).

Of particular interest are their guiding principles and dominant institutions. In a comparative perspective, liberal welfare states provide the least support and security for its citizens. Despite the persistence of the United States as a welfare state outlier characterized by rather striking shortcomings in the provision of economic security, both Canada and the United Kingdom's policy profiles are consistently found to be closer to the United States than to European welfare states where economic security and support are more assured (26).

Within liberal welfare states, the dominant ideological inspiration is that of liberty, which is associated with minimal governmental intervention in the workings of the marketplace. Indeed, such interventions are viewed as providing a disincentive to work, thereby breeding 'welfare dependence'. The results of this ideological inspiration are the meagre benefits provided to those on social assistance in Canada, the United States and the United Kingdom, generally weaker legislative support for the labour movement, underdeveloped policies for assisting families and children, and reluctance to provide universal services and programs. Programs that exist are residual, meaning that they exist to meet the most basic needs of the most deprived.

TABLE 4
Illustrative child health outcomes among differing welfare states, early 2000s

Welfare state type	Infant mortality /1000	Low birth weight /100	Death by injury /100,000	Teenage births /1000
Social democratic				
Denmark	4.4	5.5	8.1	8.0
Finland	3.1	4.1	14.9	10.0
Norway	3.4	4.9	13.0	10.0
Sweden	3.1	4.5	7.6	9.0
Mean	**3.5**	**4.8**	**10.9**	**9.2**
Conservative				
Belgium	4.3	6.5	15.1	11.0
France	3.9	6.6	12.5	10.0
Germany	4.2	6.8	13.4	14.0
Netherlands	4.8	5.4	9.0	5.0
Mean	**4.3**	**6.3**	**12.5**	**10.0**
Liberal				
Canada	5.4	5.8	14.8	20.0
Ireland	5.1	4.9	15.0	15.0
UK	5.3	7.6	8.4	28.0
USA	7.0	7.9	22.9	48.0
Mean	**5.7**	**6.6**	**15.3**	**27.8**

UK United Kingdom; USA United States. Adapted from reference 36

Political economists have argued that liberal welfare states and their ideological characteristics represent the interests of those allied with the central institution of these nations: the Market. It is no accident that these liberal welfare states have the greatest degree of wealth and income inequality, the weakest safety nets, and poorest performance on indicators of population health such as infant mortality and life expectancy, and as has been demonstrated in the present article and previous articles, mediocre performance on numerous indicators of children's health (27).

The opposite situation is seen among social democratic welfare states. The ideological inspiration for the central institution of these nations – the State – is the reduction of poverty, inequality and unemployment. Rather than seeing government responsibility as being limited to meeting the most basic needs of the most deprived, the organizing principle here is universalism and provision of social rights of all citizens. Denmark, Finland, Norway and Sweden are the best exemplars of this form of the welfare state. Governments with social democratic political economies are proactive in identifying social problems and issues, and strive to promote citizens' economic and social security. This form of the welfare state has been associated with the virtual elimination of poverty, striving for gender and social class equity, and regulation of the market in the service of citizens (28). Their indicators of children's health are excellent.

Even the so-called conservative (eg, France, Germany and The Netherlands) and Latin (eg, Greece, Italy and Portugal) welfare states generally provide superior economic and social security to their citizens than liberal welfare states (29). The ideological inspiration of maintaining social stability, wage stability and social integration is accomplished through provision of benefits based on

insurance schemes geared to a variety of family and occupational categories.

What this typology suggests is that there are strong institutional structures and historical traditions that shape how public policy is made. Canada has a tradition – compared with other wealthy industrialized nations – of minimizing governmental intervention in the operation of the marketplace. The result of minimal intervention is the existence of greater differences in living conditions among Canadian children – with resultant differences in health outcomes – than is the case in many other wealthy industrialized nations. Table 4 illustrates some of these outcomes that differ systematically among welfare state types. Note how children in the social democratic nations generally fare better than those in liberal or conservative welfare states.

Faced with evidence of these structures and traditions, and their importance for determining the degree of social and health inequalities, what are those who reside in liberal political economies to do in their attempts to improve the quality of the social determinants of health to which children are exposed? Answering this question constitutes part IV of the present series.

ADDENDUM: It is common, however, for governmental and other authorities to 'individualize' public policy issues – ie, view them as personal problems rather than public issues requiring policy responses. As an example, governmental authorities frequently choose to understand early child development as being primarily about parents' behaviours toward their children. They then focus on developing programs that promote better parenting, parents reading to their children and children's physical activity. These activities are useful, but take little account of the important role of socioeconomic circumstances of parents on their ability to accomplish these goals. Issues of reducing income, housing and food insecurity among families are neglected.

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