DEBATE

Twenty years since Ottawa and Epp: researchers’ reflections on challenges, gains and future prospects for reducing health inequities in Canada

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SUMMARY

November 2006 marked the 20-year anniversary of the Ottawa Charter for Health Promotion and Canada’s Epp Report. Encapsulating the tenets of health promotion (HP), these publications articulated a vision for reducing health inequities, and described a policy framework for achieving this vision, respectively. These documents also triggered the launch of the population health (PH) field, focused on elucidating the empirical relationships between socioeconomic gradients and population health inequities. Over two decades, a rich HP/PH theoretical and evidentiary base on socioeconomic gradients in health has established. Yet, despite valuable contributions from Canadian researchers, insufficient headway has been made in this country to achieve the Charter’s vision.

There are numerous challenges to reducing population health inequities in Canada. Informational challenges include complexity of HP/PH evidence, and inadequate knowledge translation beyond traditional targets. Institutional challenges include the relative immunity of the healthcare sector to funding reductions, and the organization of policy responsibilities into silos. Concerns from non-healthcare sectors of ‘health imperialism’, and intergovernmental tensions are interest-related challenges, while ideological challenges include lack of media discourse on health inequities and a strong neo-liberal political climate.

Gains have been made in Canada towards reducing health inequities. The HP/PH discourses are firmly entrenched in academic and policy spheres across the country, while several inter-sectoral policy initiatives are currently underway. HP/PH researchers could be more proactive in the knowledge-translation sphere by engaging other researchers outside of medicine and health, non-healthcare policy-makers, and the general public, vis-à-vis the media, on the health inequities knowledge base. Ultimately, significant and sustained progress will only be made if researchers and other champions recognize the inherently political aspect of their work and understand how to overcome ideologically driven resistance.

Key words: health promotion; knowledge transfer; health policy

INTRODUCTION

Twenty years have passed since the declaration of the Ottawa Charter for Health Promotion (WHO, 1986) and the release of Canada’s Epp Report (HWC, 1986). These documents made fundamental contributions to the task of reducing population health inequities, not only by articulating policy directives, but also by sparking academic interests in this emerging domain of research. The Charter inspired a positive vision of health and human agency: a resource made more abundant by identifying and realizing our aspirations, satisfying our needs, and coping with our circumstances by changing or adapting to them. Improving health
would require a firm and stable foundation in nine prerequisites\(^1\) and achieving these would necessitate creating healthy public policy, reorienting health services and involving a wide constituency of actors (WHO, 1986). The Epp Report endorsed the Charter’s vision and provided a policy framework for achieving it. The Charter inspired hope; the Epp Report suggested direction.

While targeted at policy-makers, some academics felt this vision and policy framework lacked the necessary substance for policy-makers to operationalize such ideas. Indeed, at this time, the empirical relationship between socioeconomic conditions of daily living and population health inequities was largely untapped—a relationship that would later prove to buttress the objectives of the Charter and Epp Report. Thus, by the early 1990s, population health (PH) had entered the health policy discourse in Canada. The Canadian Institute for Advanced Research created a PH group in 1989 and released their influential book in 1994 (Evans et al., 1994). In 1992, the Federal/Provincial/Territorial Advisory Committee on Population Health (F/P/T ACPH) was created (McKay, 2001). The PH field specialized in generating empirical evidence demonstrating the socioeconomically graded nature of health outcomes at the population level. While Health Promotion (HP) scholars were unapologetic about their pursuit of social justice and equity, the positivist paradigm commonly adopted by PH researchers discouraged this kind of ‘political’ engagement (Coburn et al., 2003). This distinction\(^2\), and the policy implications that have derived from each field as a consequence, has fuelled much of the tension between proponents of HP and PH discourses (Labonte, 1995; Poland et al., 1998; Robertson, 1998).

Despite discursive differences in HP and PH, both fields have become fundamentally concerned with improving population health outcomes. HP drew the attention of researchers and policy-makers by identifying the problem of inequitable distribution of health outcomes; PH extended the Charter’s vision by quantifying the extent of these inequities. The socioeconomic gradient in health that was articulated by PH researchers provided empirical evidence that \textit{all} Canadians are affected by health inequities, while HP scholars clarified how this statistical reality conflicted with fundamental ‘Canadian values’ (HDTG, 2004). Indeed, the ‘social determinants of health’ (SDOH) articulated by PH proponents (FPT-ACPH, 1999) were uncannily similar to the prerequisites for health articulated in the Charter. While scholars from both camps have been (and some continue to be) resistant, to others the objectives of HP and PH are clearly mutually reinforcing (Hayes, 1999). The complementarity of these objectives provides an impetus for considering their collective impact (i.e. HP/PH) on population health policy in Canada.

The last 10 years have witnessed systematic growth in research relating to population health inequities, and publication of several related policy documents (FPT-ACPH, 1996, 1999). There is general consensus among researchers that the most effective way to address social gradients is to improve the socio-economic conditions of daily living (Lynch et al., 1997; Ross et al., 2000; Wilkins et al., 2002; Marmot, 2003; Raphael, 2003d; Wilkinson, 2005). Yet Canadian policy responses have concentrated their energies on the default levers of improving access to clinical care (e.g. establishing wait-times guarantees) and reducing the incidence of morbidity and mortality caused by ‘unhealthy living’ (e.g. poor diet, tobacco use, injuries) (Raphael, 2003a, 2003b; HDTG, 2004; Gutkin, 2005; IHLN, 2005; GoBC, 2006a). As equity-minded politicians rarely constitute the governing party in Canada, progressive policy interventions that extend beyond the default levers have often been the product of political pressure from social movements or opposition parties in minority governments (Raphael and Bryant, 2006a). Meanwhile, there is considerable public and political support for initiatives that attempt to

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\(^1\) Peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice, equity.

\(^2\) HP scholars employed the phrase ‘health inequities’, which refers to unfair or unjust differences in health outcomes. In contrast, PH scholars substituted more politically neutral phrases that refer simply to measurable differences in health outcomes, such as ‘health inequalities’ and ‘health disparities’. ‘Health inequalities’ is the most widely used shorthand among academics in the PH field (Kawachi et al., 2002), while Canadian policy documents commonly employ the ‘health disparities’ descriptor (Wilkins et al., 2002; HDTG, 2004). We are primarily concerned with how the fields of HP and PH have impacted population health policy to reduce ‘health inequities’ in Canada, and we will employ this shorthand here, except in specific discussions of the health inequalities academic literature.
improve clinical care and modify behaviours (Eyles et al., 2001; Collins et al., 2007), despite academic consensus that these determinants only minimally explain social gradients in population health (Lalonde, 1974; McKeown, 1979; Black et al., 1980; Hayes and Dunn, 1998; Frankish et al., 1999; Raphael, 2003c). Clearly, the Charter’s vision and policy prescriptions for reducing health inequities, as well as the ensuing empirical research in support of this vision, have inadequately translated into policy and program development in Canada (Frankish et al., 1999; Evans, 2002; Raphael, 2003b, 2003c; Earle et al., 2006; Raphael, 2007). Using Weiss’ (1995) conceptual framework for shared decision-making, we describe a number of challenges to this translation as they relate to information, institutions, interests, and ideology.

CHALLENGES

Information

There are a number of information-related challenges to reducing population health inequities. The complexity of the HP/PH knowledge base interferes with the development of clear, evidence-based policy options to address inequities. Academic debates abound, for instance, concerning the precise empirical relationship between socioeconomic deprivation and mortality (Lynch et al., 2000; Ross et al., 2000, 2005; Marmot and Wilkinson, 2001; Kawachi et al., 2002). The persistent (albeit of waning intensity) conflict between HP and PH researchers often precludes the development of unified messages for policy-makers. In this regard, a valuable lesson may be offered by the climate change movement where considerable public and political support has coalesced from researchers otherwise pursuing a range of ideas.

The policy implications that have derived from the HP/PH knowledge base often conflict with policy-making contexts and cultures. While the SDOH framework provides a number of policy levers to target, this framework offers no explicit direction for policy-makers on which issues to address first. Similarly, there is little agreement among researchers on the relative merits of various policy strategies to reduce inequities in health (e.g., universal versus targeted programs) (Browne, 2004). Researchers often present policy options that are too broad and abstract for policy-makers to employ (e.g., income redistribution, poverty reduction), or options that have not been adequately evaluated for intended and unintended consequences (Lavis, 2002). Researchers often inadequately comprehend the reality of policy-making processes; they may conceptualize these processes as linear and rational, and assume that evidence, adequately disseminated, will translate into policy change (Glouberman, 2001). The inherently conservative, incremental process of policy-making is commonly overlooked (Lindblom, 1956). The challenges to translating research knowledge into evidence-based public policy are well-documented (Lavis et al., 2003a; Lavis, 2006; Lomas, 2007), and the experiences with HP/PH knowledge base have been no exception (Lavis, 2002; Waddell et al., 2005).

Finally, knowledge translation on socioeconomic gradients in health has been limited in scope. Medical and health journals have been the primary targets for translation within academia, whereas journals with a stronger social policy orientation have been largely excluded from this exchange. Similarly, policy-makers in the healthcare sector have been the most common targets in the policy realm, despite calls for greater collaboration with non-healthcare sectors and for development of inter-sectoral public policies to address population health inequities (FPT-ACPH, 1999; Evans, 2002).

Institutions

The policy-making realm presents other challenges. In Canada, the healthcare sector represents the largest proportion of government expenditures. This funding structure is counterproductive to reducing health inequities in a number of ways: it fortifies the funding status of clinical care (the dominant mode of care in the healthcare sector) relative to other sectors; it legitimizes the work that goes on within that sector (downstream treatment as opposed to upstream investment); it conveys a message concerning what constitutes public goods and how these goods should be prioritized; it creates a strong culture of entitlement within healthcare; and it fosters resentment from non-healthcare sectors concerning their compromised funding

3 While there clearly is overlap between these four dimensions, we have chosen to use this conceptual framework to facilitate discussion of the key challenges.
status. These tensions were illuminated in an experiment in Prince Edward Island (PEI) (Stoddart et al., 2006). Designed to ease inter-sectoral reallocation of government funding to reduce population health inequities, the results of this experiment demonstrated tremendous resistance to shifting funds out of healthcare and into other sectors. The organization of policy responsibilities into silos poses structural constraints to inter-sectoral collaboration, and is the primary barrier that the PEI experiment attempted to overcome (Nutbeam, 1999; Lavis et al., 2003b).

Other policy challenges relate to support for HP/PH messages in government institutions. Health Canada has nurtured the HP/PH approach through its own policy rhetoric (Lalonde, 1974; FPT-ACPH, 1999; HealthCanada, 2001), but as jurisdiction for health services (and other important determinants such as social services and education) falls squarely on the provinces and territories, it has limited capacity to act on this rhetoric. Despite being exposed to rhetoric that presumes an undifferentiated Canada, the fiscal capacity and political will to address population health inequities differ greatly between provinces and territories. For instance, Alberta, Canada’s wealthiest province, has the lowest welfare rates for lone parents, whereas Newfoundland and Labrador, one of the country’s poorest provinces, has the highest rates (NCW, 2006). Meanwhile, the portfolios of ministers and advisors change regularly, making it difficult for researchers to maintain salience of HP/PH issues among decision-makers, and to generate political support for long-term interventions that the HP/PH fields prescribe.

**Interests**

Conflicting interests of policy actors also present challenges to reducing population health inequities. For instance, population health researchers emphasize the need for policy-makers to adopt a ‘life-course perspective’ in developing policies and programs to reduce socioeconomic gradients in health. Yet, this perspective evades the compartmentalized, localized and short-term logics of most policy interventions, and the short-term interests of politicians seeking re-election (Hayes and Dunn, 1998). The (perceived) political risks involved in adopting this life-course perspective in policy-making (e.g. foregoing campaign contributions and electoral support) is a sufficient deterrent for policy-makers confronted with a host of more politically palatable options for spending tax-payers’ money. The tensions between evidence-based policy prescriptions and the vested interests of policy-makers, politicians and stakeholder groups to ignore such evidence are often overlooked by health inequities researchers (Wainberg, 2006).

Conflicting interests within bureaucracies also present significant challenges to reducing health inequities. For instance, as described earlier, health sector budgets have ballooned at the expense of non-health sector budgets. Thus, any attempt to engage non-health sectors in health goal setting or policy activity related to the SDOH framework is viewed as ‘health imperialism’ and met with intense resentment (Glouberman, 2001; Lavis, 2002). This resentment has reinforced ideological resistance to collaboration between policy-makers from different sectors, especially from powerful finance sectors (Lavis et al., 2003b).

**Ideology**

Conservative political ideology (in particular, neo-liberalism) is one of the most powerful barriers to addressing population health inequities, influencing many steps along the pathway of progressive public policy development and implementation. At the top of the chain are conservative politicians who lack the political will to address socioeconomic gradients in health. Policy implications that generate the least political will, such as income redistribution, are believed to have the greatest potential to reduce inequities, while substantial will for action exists for the least influential policies (e.g. expanding clinical healthcare services) (Evans, 2002; Lavis et al., 2003b; Wilkinson, 2005). There is also little incentive for politicians to support progressive social policies to address population health inequities because of the typically long time lag to realize the benefits of those policies (Hayes and Dunn, 1998). For instance, despite evidence demonstrating the profound life-long benefits of interventions like universal day-care (Hertzman and Wiens, 1996), one of the first orders of business for the newly elected federal Conservative government in Canada was to scrap the widely anticipated universal day-care program in favour of a tax break.
for families with children under six (DoF, 2006).

The minimal attention politicians pay to the non-medical determinants of health in turn shapes the pattern of news media coverage on public policy. With few exceptions (Picard, 2006), Canadian news media has historically been silent on health inequities (Raphael, 2003c, 2007; Hayes et al., 2007). Health stories that capture media attention are typically those concerning Canada’s healthcare system (Hayes et al., 2007). This narrowly focused health news coverage not only reduces public awareness on the SDOH (Stoddart et al., 2006), but also fosters misconceptions that ‘health equals health care’, and reinforces public resistance to health care reform (e.g. hospital closures) (Abelson, 2001). Interest groups (e.g. physicians and allied professionals, pharmaceutical companies, biotechnology industry), in particular, play powerful roles in accessing sympathetic media outlets, keeping the public discourse focused squarely on healthcare, and reinforcing the silence of news coverage on health inequities (Evans, 2002; Raphael, 2003c; Stoddart et al., 2006).

Narrow media coverage leads to narrow public opinion. Research has shown that the Canadian public generally views personal lifestyle behaviours as the most important contributors to health, and consider broader social determinants to have minimal bearing on health outcomes (Eyles et al., 2001; Raphael, 2003e; CIHI, 2005; Collins et al., 2007). When given an opportunity to ponder the issues, Canadians have demonstrated their capacity to understand health inequities as broader socio-structural problems to be tackled by progressive public policy (Reutter et al., 1999, 2006). However, the public is rarely presented with such opportunities to engage on the issues, forced instead to provide ill-informed reactionary opinions on public policy issues to which politicians are more likely to respond.

A misinformed citizenry is unlikely to spur governments into action to reduce health inequities. For some Canadians, their political ideology fundamentally conflicts with the HP/PH discourses (Collins et al., 2007), but for others, increasing awareness of the SDOH may offer the much needed impetus to compel their leaders to act (Nutbeam, 2000). Addressing social gradients in health outcomes requires public investments that cross boundaries of class, space and time. The willingness to make such investments hinges on how we construct ‘distant strangers’ we do not know (Ignatieff, 1984). The current ideological climate of neoliberalism reflects and reinforces short-term policy interventions that favour continued and increased funding to address perceived urgent problems of today, rather than investments to create better health outcomes in the future.

IMPORTANT GAINS AND AVENUES FORWARD

Despite these challenges, a number of important gains have been made to reduce health inequities in Canada. Drawing on the growing spirit of knowledge translation in Canada, more productive exchanges between researchers and policy-makers have developed in the context of the SDOH (Waddell et al., 2005). These exchanges, as well as strong public relations capacities, are the focal point of activities for the Canadian Population Health Initiative—an independent, non-profit organization specializing in disseminating population health evidence into policy prescriptions. HP/PH research in Canada has been further enhanced by the institutionalization of a number of new public health university programs. There is growing advocacy for knowledge brokering in this field, in recognition of the difficulties academics confront in effectively translating their research (Waddell et al., 2005; Lomas, 2007).

Further gains could be made by improving knowledge translation of HP/PH research. One minor, yet important, step in this regard would be to lobby PubMed and Medline administrators for the expansion of Medical Subject Headings to more accurately reflect the domain of HP/PH research (e.g. ‘health inequities’, ‘health inequalities’, ‘population health’, ‘social gradients’). A new (possibly international) journal could be established to cater to dissemination of research on population health inequities. This is especially relevant given that most existing journals assume their readerships ascribe to either HP or PH, despite increased recognition of the complementarity in their research agendas and policy prescriptions.

Institutional challenges are more difficult to overcome than those relating to information, but a number of positive steps have been made. The creation of the Public Health Agency of
Canada has been a necessary development in the institutionalization of, and increased awareness of, the HP/PH discourses. While the results were predominantly regressive in terms of reducing population health inequities, the PEI experiment provides a valuable learning experience for researchers and policy-makers aiming to implement inter-sectoral policy strategies to reduce health inequities (Stoddart et al., 2006). The Healthy Living Strategy developed by the F/P/T ACPH (IHLN, 2005) and the ActNowBC initiative (Hazlewood, 2006) demonstrate two innovative attempts to establish healthy public policy at higher levels of administration that are applicable across jurisdictions and governmental sectors. The primary objectives of these initiatives, however, are focused on improving individual lifestyles, and thus fall far short of addressing socioeconomic gradients in population health. These initiatives provide instructive frameworks for inter-sectoral policy-making, but their objectives should more accurately reflect the HP/PH evidence base if reductions in social gradients in health are desired.

Some of the most innovative and progressive programs tackling the SDOH in Canada are emerging from organizations outside the health sector. The Federation of Canadian Municipalities, for instance, is funding an affordable housing program (FCM, 2001), while the Association of Community Organizations for Reform Now is campaigning to have predatory lending agencies regulated (ACORN, 2005). Among a number of programs, the Ontario Coalition Against Poverty is campaigning to raise the welfare rates in Ontario (OCAP, 2005), and to stop illegal deportations (OCAP, 2006). Meanwhile, the United Way of BC’s Lower Mainland is currently partnered with the Canadian Labour Congress to ensure that workers are equipped with information about social services in their community (UWLM, 2005). Given their natural affinity to issues concerning social justice and equity, HP/PH researchers might also consider widening dissemination efforts to social service and advocacy groups outside the health sector.

There are other ways in which researchers could overcome institutional challenges. For instance, the HP/PH discourses could be framed in ways that encourage participation from non-healthcare policy makers (Lavis, 2002), and in ways that shift the policy focus off largely ineffective interventions that target individual-level behaviours. Offering personal invitations to policy advisors to academic conferences disseminating HP/PH research is one approach to facilitate increased exchange between these groups. Forming partnerships with stakeholders that have vested interests in reducing population health inequities (e.g. Chronic Disease Prevention Alliance of Canada) is another avenue worth pursuing (Hancock, 2001).

Interest-related and ideological challenges are the most difficult, but the most important, to overcome if the HP/PH agenda is to be advanced. Generating supportive public opinion through increased engagement may facilitate the most immediate and lasting effects on oppositional neo-liberal ideology. Public support for addressing health inequities is necessary to create a supportive research environment that is maintained by public funding bodies, and especially to create a favourable policy environment within which intervention is tolerated. In this respect, progress has been made in creating a more supportive citizenry. Health Canada’s support for the HP/PH discourses has been critical to the institutionalization and legitimacy of SDOH framework, and for making the SDOH evidence base publicly accessible. As well, the BC government is currently engaging the public in a ‘Conversation on Health’ that stimulates dialogue on healthcare spending (GoBC, 2006b). Perhaps most promising, recent opinion polls suggest Canadians are placing higher priority on climate change (Bueckert, 2006), reflecting a capacity and willingness to consider long-term outcomes to which they may never bear witness.

While some segments of the general public will always be resistant to reducing socioeconomic gradients in health, the prospect of reducing health inequities conforms to the values held by many Canadians; the missing ingredient is information. Thus, informing the general public of the HP/PH evidence base should be of utmost priority to researchers and policy-makers interested in translating knowledge into policy action. A media discourse on health inequities needs to be established in order to facilitate public dialogue and to challenge those with resistant opinions. One way to achieve this would be to engage key health and social policy commentators in dissemination efforts (e.g. inviting public health reporters to conferences). If an informed citizenry, equity-minded social service providers and the public health
community were to join forces, the knee-jerk opposition to addressing the SDOH generated from conservative ideologues could be overcome.

Relevance to other countries
Countries with high degrees of income inequality have lower average life expectancies; yet the level of income inequality in Canada is lower than many OECD countries (Wilkinson, 2005). Thus, the Canadian experience of pervasive health inequities is not unique. And, like Canada, most OECD countries devote at least 70% of their public expenditures to spending on health (OECD, 2006). Developed countries around the world recognize the importance of maintaining a healthy population, and the need for state intervention to realize this goal. Yet, population health differences between countries remain despite relatively comparable health expenditures. These differences are likely attributable to political ideology, which influences the strength and sophistication afforded to the welfare state (Navarro and Shi, 2001), and whether the governing party is a champion for the task of reducing health inequities (Raphael and Bryant, 2006b). The political tradition in Canada—liberal, Anglo-Saxon, democracy—is most comparable to that in the UK and USA, and has been characterized as being pro-capitalist with minimal state interference in the market, little support for unionization, low wages and generally weak welfare states (Navarro and Shi, 2001). The challenges to reducing health inequities in Canada may well resonate with the experiences in ideologically similar jurisdictions.

CONCLUSIONS
The hope embodied in the Ottawa Charter has not yet been realized in Canadian policy developments to reduce population health inequities. The challenges to translating knowledge into action are diverse, and signal the need to rethink, repackage and resell HP/PH messages: to broaden dissemination within and outside academia; to coordinate public policy strategies that engage non-healthcare sectors; to increase public awareness of the SDOH; and to generate political will for change. Clearly, it is a marathon, not a sprint. How far will the next 10 years take us?

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