Do great local minds think alike? Comparing perceptions of the social determinants of health between non-profit and governmental actors in two Canadian cities

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Received on June 10, 2011; accepted on January 12, 2012

Abstract
Cities are important sites for intervention on social determinants of health (SDOH); yet, little is known about how influential local actors, namely workers in municipal governments (GOVs) and community-based organizations (CBOs), perceive the SDOH. Capturing and comparing perceptions between these groups are important for assessing how SDOH discourse has permeated local actors’ thinking—a meaningful endeavour as local-level health equity action often invokes inter-institutional partnerships. This paper compares SDOH perceptions between CBO workers in Hamilton, Ontario, with politicians and senior-level staff in GOVs in Vancouver, British Columbia, based on two studies with surveys containing identical questions on SDOH perceptions. Overall, there was high comparability between the groups in their relative ratings of the SDOH. Both groups assigned high levels of ‘influence’ and ‘priority’ to ‘healthy lifestyles’ and ‘clean air and water’ and lower levels to ‘strong community’ and ‘income’. Given the importance of a shared vision in collaborative enterprises, the comparability of perceptions between the groups found here holds promise for the prospect of inter-institutional partnerships. However, the low rating assigned to more structural health determinants suggests that more work is needed from researchers and advocates to effectively advance a health equity agenda at the local level in Canada.

Introduction
The SDOH, local health inequities and barriers to action
The ‘social determinants of health’ (SDOH) are social risk factors that shape population health inequities. While a variety of conceptual frameworks describing the SDOH have emerged over the past two decades, there is considerable overlap between these frameworks in terms of key determinants and mechanisms of influence [1–4]. The Public Health Agency of Canada has identified 12 health determinants, offering a comprehensive list of policy and service domains to which interventions could be targeted to alleviate health inequities [5].

Understanding the determinants of, and potential interventions to address, health inequities is especially important in cities. Internationally, population growth is occurring predominantly in urban agglomerations [6]; within Canada, nearly half the population lives in one of six large metropolitan regions [7]. These growing urban systems create and perpetuate immense socio-economic disparities, often leading to dramatic inequities in population health within city limits [8–10]. Meanwhile, in Canada and internationally, large cities are often home to major hospitals, universities, influential non-governmental organizations, a well-organized public health sector and interest groups with significant mobilization capacities [11]. Thus, cities offer critical sites for interventions on health inequities through action on the SDOH [12].
The persistence of population health inequities highlights a tremendous gap between knowledge and action on the SDOH [13, 14]. A number of barriers to action have been documented in Canada [15], including conceptual challenges in the translation and exchange of a complex and largely unpublicized knowledge base [16–18], structural challenges with the organization of policy responsibilities into sectoral silos [19] and sociopolitical challenges stemming from welfare state retrenchment [20, 21]. Yet, action on population health inequities may be further stifled by how the SDOH are perceived, especially among actors with capacity to influence action on these determinants. Given the importance of cities as sites for intervention on health inequities in Canada and the fact that issue salience is critical in bringing new issues onto policy and planning agendas [22, 23], assessing the ways in which SDOH concepts have permeated the thinking of influential actors working at the city level is an important endeavour.

**Evidence on perceptions of SDOH**

Limited research has been conducted on SDOH-related perceptions. Among studies focusing on lay publics, individual lifestyle choices were perceived as the most important health determinant [24–27], promoting a culture of victim blaming for poor health outcomes [28, 29]. While other determinants were recognized as important, such as social supports [25, 27], poverty [30] and physical environments [31], the influence of these determinants was consistently perceived to be secondary to lifestyles.

An even smaller number of studies have surveyed the SDOH-related perceptions of influential actors working within the domains of health and social policy in Canada. One study observed a high level of importance assigned to lifestyles by health care administrators and practitioners in one of Canada’s provinces [31], while another study in a different Canadian province observed minimal consensus among health district decision makers on how the SDOH influence health outcomes [32]. Meanwhile, a survey of federal and provincial civil servants in Canada observed openness to the SDOH among those in departments of labour, social services and health but resistance among those in departments of finance that have considerable control over other departments’ budgets [33].

**Evidence gap on SDOH perceptions at local level**

Despite these research efforts, little is known about how the SDOH are perceived by key practitioners and policy makers working in cities, namely community-based organizations (CBOs) and municipal governments (GOVs). The involvement of CBOs has been acknowledged as a key step in alleviating health inequities [34, 35] because they play critical roles in addressing health determinants (e.g. employment, housing, income, food security, social supports, etc.) through the programmes and services they deliver [36]. Additionally, CBOs, and the non-profit sector more broadly, play fundamental roles as advocates for progressive public policy in Canada, despite increasingly strict regulations on these activities from government funders [37–39]. Similarly, GOVs in Canada bear responsibility for development of policies, plans and programs that directly impact the determinants of population health, such as environmental services, affordable housing, urban design, public safety, transportation infrastructure, public health and social welfare programs, day care and parks and recreation facilities [40–42]. Meanwhile, as municipalities shift towards more entrepreneurial approaches to governance [43], these organizations are increasingly working together in collaborative enterprises to effect change in their communities [44, 45]. Thus, capturing SDOH-related perceptions of these groups is critical for understanding how SDOH discourses have permeated the thinking of influential local actors and for anticipating the types of interventions that these actors would mutually oppose or support.

This paper delivers a descriptive comparative analysis of the SDOH perceptions held by individuals working in CBOs and GOVs in two Canadian municipal regions. This analysis is based on results generated from two separate studies conducted by the author; the first surveyed individuals working in CBOs in Hamilton, Ontario, and the second surveyed individuals working in GOVs in Vancouver,
British Columbia. While these surveys were conducted in different sites, at different times and among different populations, the surveys were developed and administered using the same methodology, and SDOH perceptions were captured using nearly identical questions.

**Methods**

**Study sites**

The two studies were conducted approximately 4.5 years apart, and each employed a mail-administered survey to capture SDOH-related perceptions of the target samples. A summary of the study sites is provided in Table I. Key similarities between the study sites include the scope of municipal responsibilities, as well as median age, household income and per cent owner occupied dwellings. Notable differences between the study sites include population size and density, amalgamated status of the municipalities and percentages of immigrants and university-educated residents. Key contextual differences between the two study sites are described below.

Hamilton, Ontario, has been a hub for steel manufacturing in Canada for over a century [51]. This long history of heavy industrialization has resulted in significant pollution and environmental destruction to the area [52] and recent commitment from the City of Hamilton to work towards environmental and ecological remediation [53]. Higher than average unemployment rates have become a

<table>
<thead>
<tr>
<th>Study institution and timeframe</th>
<th>CBO study</th>
<th>GOV study</th>
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<tbody>
<tr>
<td>Institution granting ethics approval</td>
<td>McMaster University</td>
<td>Simon Fraser University</td>
</tr>
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<td>Ethics approval date</td>
<td>August 2003</td>
<td>October 2007</td>
</tr>
<tr>
<td>Survey administration timeframe</td>
<td>September to October 2003</td>
<td>January to February 2008</td>
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<tr>
<th>Study site characteristics [46, 47]</th>
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<th>GOV study</th>
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<tbody>
<tr>
<td>Site name</td>
<td>Hamilton Census Division*a</td>
<td>Vancouver Census Division</td>
</tr>
<tr>
<td>Population</td>
<td>504 559</td>
<td>2 116 581</td>
</tr>
<tr>
<td>Land area (km²)</td>
<td>1 117</td>
<td>925</td>
</tr>
<tr>
<td>Density (population km⁻²)</td>
<td>452</td>
<td>736</td>
</tr>
<tr>
<td>Jurisdictional authority</td>
<td>Amalgamated entity, with authority over six geographical areas</td>
<td>A variegated region, with 23 autonomous municipalities [48]</td>
</tr>
<tr>
<td>Proincal jurisdiction</td>
<td>Ontario</td>
<td>British Columbia</td>
</tr>
<tr>
<td>Major municipal government responsibilities (same for both sites)</td>
<td>Transportation, police and protection, health and social services, environmental services and infrastructure, recreation and cultural services [49]</td>
<td></td>
</tr>
<tr>
<td>Primary sources of employment (as % of total experienced labour force 15 and over)</td>
<td>1. Manufacturing (16%)</td>
<td>1. Business services (24%)</td>
</tr>
<tr>
<td></td>
<td>2. Business services (16%)</td>
<td>2. Retail trade (11%)</td>
</tr>
<tr>
<td></td>
<td>3. Health care and social services (12%)</td>
<td>3. Health care and social services (9%)</td>
</tr>
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<th>Study site population demographics[46, 47]</th>
<th>CBO study</th>
<th>GOV study</th>
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<tbody>
<tr>
<td>Median age (%)</td>
<td>39.6</td>
<td>39.1</td>
</tr>
<tr>
<td>Median household income ($)</td>
<td>66 810</td>
<td>64 332</td>
</tr>
<tr>
<td>Low income after tax (%)</td>
<td>14.0</td>
<td>16.5</td>
</tr>
<tr>
<td>Over 15 years with university degree (%)</td>
<td>15.5</td>
<td>24.6</td>
</tr>
<tr>
<td>Unemployment rate (%)</td>
<td>6.5</td>
<td>5.6</td>
</tr>
<tr>
<td>Owner occupied dwellings (%)</td>
<td>68.3</td>
<td>65.1</td>
</tr>
<tr>
<td>Immigrant (%)</td>
<td>25.4</td>
<td>39.6</td>
</tr>
<tr>
<td>Aboriginal (%)</td>
<td>1.5</td>
<td>1.9</td>
</tr>
</tbody>
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*a A Census Division is defined by Statistics Canada as a ‘group of neighbouring municipalities joined together for the purposes of regional planning and managing common services (such as police or ambulance services)’ [50].
significant concern in Hamilton as steel manufacturing jobs have been lost amidst a highly competitive global market [54]. Despite Hamilton’s woes with steel, it has become a hub for employment in health sciences research and health care services, with the Hamilton Health Sciences Corporation now the largest employer in the city [51]. And, owing to its long-standing connections with labour movements, Hamilton has become a political stronghold for the New Democratic Party over the past decade [55].

Vancouver is one of Canada’s most picturesque city regions, nestled between the Pacific Coast Mountains and the Pacific Ocean. As one of Canada’s metropolitan centers, Vancouver is a major hub for immigration, with close to 40% of its population born outside of Canada [46]. In recent years, Vancouver has been consistently named one of the world’s top 10 most liveable cities by ‘The Economist’ magazine [56], although its ratings from Canada’s ‘MoneySense’ magazine have historically been much lower [57]. Vancouver has a relatively diverse economic profile, but it is the least affordable place in Canada to buy a home; average house prices in 2010 for Vancouver approached $700 000, with Victoria, BC, a distant second, at around $475 000 [58]. Lack of affordable housing has stimulated urban sprawl in the outlying municipalities, leading to traffic congestion along its limited highway infrastructure [58]. Stemming from lack of affordable housing, homelessness and drug addiction are significant problems in the downtown core of Vancouver [59, 60], as well as Vancouver’s neighbouring municipalities [61, 62].

Sampling strategies
The CBO study surveyed individuals that work, on either a paid or a voluntary basis, for a CBO in the Hamilton Census Division. This stratified random sample was generated from the Redbook Plus [63], a publicly accessible computerized database of organizations in the community, ranging from health clinics, food banks, employment resources, immigrant assistance, income advocacy, environmental conservation and seniors’ clubs. More complete sampling details have been reported elsewhere [64]. The final target sample for the CBO survey was n = 436.

The GOV study surveyed all politicians and senior-level staff working in 17 of the 22 member municipalities in the Vancouver Census Division (the Villages of Anmore, Belcarra and Lions Bay, the Municipality of Bowen Island and the Greater Vancouver Electoral District A were excluded due to their small size) [48]. Library directors, police and fire chiefs and deputy chiefs were included in the study, as were non-senior staff members when they were the only representative for a given department. More complete details of the sampling procedures can be found elsewhere [65]. The final target samples was n = 652.

Survey objectives, development and administration
The objective of the CBO study was to assess the relationship between participants’ SDOH-related perceptions with their values and political orientations. The survey consisted of questions items on SDOH-related perceptions, SDOH-related values, political orientations and activities and participants’ role in the CBO. The objective of the GOV study was to assess the relationship between participants’ SDOH-related perceptions with their views on how, and by whom, the SDOH should be addressed at the local level. The survey consisted of questions on SDOH-related perceptions, perceptions concerning the responsibility of municipalities and other sectors to address the SDOH and municipal policy levers and constraints on addressing SDOH.

Two multi-item questions on SDOH-related perceptions that were initially developed for the CBO survey were also posed, nearly verbatim, in the GOV survey. The first question asked ‘How influential do you think each determinant listed below is to the health and well-being of people living in Hamilton?’, while the second question asked ‘What level of priority do you believe should be given to addressing these determinants of health to improve the health and well-being of people living in Hamilton?’. The only difference between the two surveys was the substitution of ‘Hamilton’ in the CBO survey for ‘your municipality’ in the GOV survey. Each response item in the two questions was designed to capture each of PHAC’s SDOH; all
12 determinants were assessed in the influence question, while 9 of the 12 determinants (i.e. those considered amenable to change) were assessed in the priority question.

The administration of both surveys involved contacting eligible participants on five occasions to encourage their participation: prenotice letter (Day 1), survey package #1 (Day 4), reminder postcard (Day 18), survey package #2 (Day 25), phone call/email follow-up (Day 30) [66]. The final contact was the only point of methodological difference in the way the surveys were administered; telephone correspondence was used for the CBO survey because availability of email addresses was inconsistent, while email correspondence was used in the GOV survey. The CBO survey was administered in September 2003, and the GOV survey was administered in January 2008.

Rigour
A number of steps were taken in both studies to ensure rigour [66]. In the CBO study, sampling error was minimized through a stratified random sampling approach, while coverage error was minimized through the comprehensive directory of all CBOs in the Hamilton CD. Both sampling and coverage error were minimized in the GOV study because a census was conducted (rather than seeking a representative sample). Measurement error was minimized in both studies by adapting survey questions from existing surveys [31] and by having the surveys peer reviewed and pilot tested before administration. Internal consistency for the questions on SDOH-related perceptions, measured using Cronbach’s Alpha, ranged from 0.669 to 0.821. Test–retest reliability was assessed through follow-up surveys for both studies ($n = 24$ for CBO study and $n = 26$ for GOV study) and ranged from 0.799 to 0882 for the two multi-item questions on SDOH-related perceptions.

Statistical analyses
The survey data were managed and analysed using SPSS version 19. Chi-squared and Mann–Whitney $U$ tests were used to measure differences in demographic profiles between the two groups. Comparisons of SDOH-related perceptions between the two groups were performed using the mean levels of ‘influence’ and ‘priority’ assigned to each determinant. Within the two groups, paired samples $t$-tests were used to measure the degree of correspondence between the levels of influence and priority that were assigned by participants to each determinant. Statistical significance was based on a 99% confidence level.

Results

Response rates and participant characteristics
Response rates for the two surveys were highly comparable; 55% (241/436) for the CBO survey and 54% (345/637) for the GOV survey. The majority (72%) of CBO participants were volunteers, while 71% of GOV participants were city staff. Approximately half the participants in both samples occupied positions of considerable influence within their organization or municipality; 52% of CBO participants were presidents, vice presidents, executive directors or board members, and 50% of GOV participants were city councillors, city managers, departmental directors or deputy directors. Significant differences were observed between the two survey groups for all demographic characteristics (Table II). The CBO participants were mostly females without university degrees, earning annual household incomes under $80 000, while GOV participants were primarily males over 50, with university degrees and higher incomes.

Between-group comparisons of perceived influence and priority for the SDOH
Mean levels of influence and priority assigned to each SDOH by both samples are displayed in Fig. 1 ($1 = ‘not influential at all’/‘not a priority at all’$ to $5 = ‘extremely influential’/‘very high priority’$). Compared to GOV participants, CBO participants assigned higher influence and priority to every determinant except ‘income’. When examined as a whole, the same general patterns were observed
between CBO and GOV groups for perceived levels of influence and priority for the SDOH. For influence, both groups assigned high levels to ‘healthy lifestyles’ and ‘clean air and water’ and low levels to ‘gender’ and ‘culture and tradition’. Both groups assigned the highest priority to clean air and water and healthy lifestyles and the lowest to income.

Within-group comparisons of perceived influence and priority for the SDOH

An assumption in both these studies was that perceptions of influence and priority would correspond; that is, that participants would assign high priority to determinants that they felt were highly influential and low priority to those perceived to be less influential. Figure 2a and b illustrates the extent of correspondence in mean ratings between perceived influence and priority for each SDOH within each sample. Correspondence in perceived influence and priority (i.e. no significant difference) was observed for five SDOH among CBO participants and for only two determinants among GOV participants (Table III). Both groups assigned significantly higher levels of influence than priority to income, social supports and healthy lifestyles and significantly lower levels of influence than priority to health care.

Discussion

Demographic differences between CBO and GOV actors

The majority of CBO participants were volunteers in their organizations, contrasting starkly with the GOV sample that consisted entirely of paid employees (i.e. politicians and staff). Also of stark contrast were the sociodemographic profiles of the two groups as the majority of CBO participants were younger, female and had lower levels of education and income compared to their GOV counterparts, mirroring current gender disparities in employment sectors across Canada [67]. Approximately half of participants from both samples occupied influential positions within their organization (e.g. presidents and board members) or municipality (e.g. city councillors and departmental directors), supporting the assumption that these actors’ views could shape their organizations’ activities to address local health determinants and correspondent inequities.
Comparing local actors’ views on health determinants

Fig. 1. Comparisons between CBO and GOV participants in (a) mean levels of ‘influence’ and (b) mean levels of ‘priority for action’.
Fig. 2. Correspondence in mean levels of ‘influence’ and ‘priority for action’ for (a) CBO participants and (b) GOV participants.
Similarities in perceptions of the SDOH as a whole

Despite their demographic differences, there was considerable similarity between these groups in the overall patterns of influence and priority assigned to the SDOH. The same determinants were assigned relatively high, moderate and low levels of influence and priority (Fig. 1a and b), suggesting that the ways in which these determinants are understood and prioritized among influential local actors in Canada transcends individual-level characteristics, such as demographics or location.

Perceptions between the two groups were noticeably more comparable for influence (Fig. 1a) than priority (Fig. 1b). These findings suggest a degree of consistency and predictability in how the literature has permeated understandings of the SDOH among diverse actors in Canada, while perceptions of priority for the SDOH appear to be influenced more by contextual factors, such as occupation type, geography and demographics. These findings make sense given the tendency for attitudes and opinions to be more amenable to change as contexts change, while the underlying knowledge and values that shape them are generally more stable over time [68, 69].

Similarities in perceptions on key health determinants

The relatively high ratings assigned to healthy lifestyles in this study have been observed elsewhere in Canada [25, 26, 31] as well as the UK [27], suggesting that individualistic views about responsibility for health are deeply engrained in the psyches of Canadians. The prevalence of these views among Canadians, as reported in this study and in several others, is rather disconcerting, given the important role socio-economic status plays in determining lifestyle choices [70, 71] and given the need for progressive social and economic policy and planning to increase socio-economic status and improve health [72, 73].

While there is a distinctly ‘local’ component to the clean air and water health determinant, it is reasonable to believe that each group assigned high ratings to this determinant for different reasons. CBO participants’ ratings were likely influenced by their city’s experiences with heavily polluting manufacturing activities, and the detrimental impacts those activities have had on the local landscape [74]. In contrast, the high ratings by GOV participants for this determinant might have been driven more by their roles in their organizations, given that municipal and regional governments in Canada are primarily responsible for this determinant [41, 75]. Regardless of their reasoning, both groups did perceive this to be a key health determinant, echoing views articulated in public opinion research in Canada [26] and elsewhere [27].

From a health equity perspective, the findings from this comparative case study analysis are worrisome. The low relative ratings assigned to income by both groups is discouraging, given the importance of

<table>
<thead>
<tr>
<th></th>
<th>CBO Influence</th>
<th>CBO Priority</th>
<th>Paired samples t-test, P-value</th>
<th>GOV Influence</th>
<th>GOV Priority</th>
<th>Paired samples t-test, P-value</th>
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<tbody>
<tr>
<td>Income</td>
<td>3.90</td>
<td>3.44</td>
<td>&lt;0.001</td>
<td>3.97</td>
<td>3.12</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Social supports</td>
<td>4.08</td>
<td>3.67</td>
<td>&lt;0.001</td>
<td>3.90</td>
<td>3.29</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Education</td>
<td>3.94</td>
<td>3.96</td>
<td>NS</td>
<td>3.90</td>
<td>3.86</td>
<td>NS</td>
</tr>
<tr>
<td>Jobs</td>
<td>4.21</td>
<td>4.14</td>
<td>NS</td>
<td>3.82</td>
<td>3.67</td>
<td>0.001</td>
</tr>
<tr>
<td>Strong community</td>
<td>3.51</td>
<td>3.59</td>
<td>NS</td>
<td>3.29</td>
<td>3.60</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Clean air and water</td>
<td>4.63</td>
<td>4.63</td>
<td>NS</td>
<td>4.14</td>
<td>4.24</td>
<td>0.008</td>
</tr>
<tr>
<td>Healthy lifestyles</td>
<td>4.64</td>
<td>4.47</td>
<td>&lt;0.001</td>
<td>4.51</td>
<td>4.38</td>
<td>0.001</td>
</tr>
<tr>
<td>Early childhood</td>
<td>4.20</td>
<td>4.19</td>
<td>NS</td>
<td>4.04</td>
<td>4.07</td>
<td>NS</td>
</tr>
<tr>
<td>Health care</td>
<td>4.13</td>
<td>4.39</td>
<td>&lt;0.001</td>
<td>3.54</td>
<td>3.79</td>
<td>&lt;0.001</td>
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income in creating material opportunities to lead healthy lives and the role of income redistribution in minimizing psychosocial harms associated with income inequities [76]. Similarly, low levels of support for income have been reported elsewhere in Canada [26]. The low priority assigned to ‘culture and tradition’ is surprising given the ethnically and culturally diverse populations that these survey participants serve and also discouraging in light of the clear role that cultural, ethnic and racial identities play in the conditions of daily living in this country [77]. Finally, that participants perceived ‘gender’ to bear relatively little influence on the health of populations is troubling as women are more likely than men in Canada to be poor, earn less money and be under-employed or precariously employed [78], as well as experience higher rates of food insecurity [79] and domestic violence [5]. The low rating that CBO participants assigned to gender is particularly surprising, given that the majority of these participants were women, working in non-profit organizations that likely serve client bases with high proportions of women.

Correspondence of perceptions of influence and priority on the SDOH

Both groups assigned significantly more influence than priority to healthy lifestyles and income. One possible explanation for the low correspondence between perceptions of healthy lifestyles is that these actors are aware of the evidence base on built environment impacts on healthy lifestyles [80–84], but do not feel responsible and/or empowered to improve it. A more likely explanation, however, is that these participants view healthy lifestyles to be the responsibility of individuals rather than state and non-profit sectors, as reflected in neo-liberal discourse and ideology in Canada [85]. The significantly lower level of priority assigned to income lends further support to this theory as the results imply resistance among participants to interventions that would increase absolute income levels (e.g. increasing welfare payments) and reduce relative income inequalities.

It is also noteworthy that both groups assigned significantly higher priority than influence to health care. As observed in other Canadian studies [31,86–88], resistance to deprioritizing health care occurs regardless of the established limitations of health care systems and services in improving health outcomes [89], preventing disease and illness [5] and reducing population health inequities [90]. The unwillingness among Canadians to shift health spending in a way that would favour health promotion and disease prevention, rather than the provision of ‘sick care’ services, is a major barrier to advancing a determinants of health agenda in Canada.

Legislative powers and welfare state retrenchment

While CBOs and GOVs across Canada exert considerable influence over the conditions of daily living at the local level, their power and capacity to effect change at the policy level are limited, especially for structural determinants like ‘income’, ‘education’ and ‘employment’. CBOs are continually under-funded and devalued through welfare state retrenchment [39] and afforded little opportunity to advocate for clients and the wider communities that they serve [38]. Meanwhile, as creatures of the province, municipalities in Canada have ever-increasing responsibilities bestowed upon them by the provinces and limited revenue-generating capacity to fulfil such duties [91].

This sociopolitical context of limited legislative power and welfare state retrenchment in Canada helps to shed light on the implications of the study findings. Corresponding with and implicitly endorsing the neo-liberal agenda, both groups assigned the highest levels of influence and priority to those determinants for which responsibility is typically assigned to either individuals (i.e. healthy lifestyles), parents (i.e. early childhood) or municipalities (i.e. clean air and water) and lower levels of influence and priority to those determinants that have already become devalued through claw backs in public sector spending in Canada (i.e. income and education).

Limitations

A few limitations in this comparative analysis are noteworthy. Firstly, it was not possible to systematically measure non-response bias in the
samples because demographic characteristics of non-responders were unavailable. Non-response bias was minimized in both studies through vigorous and sustained follow-up with all non-respondents to maximize response rates.

The time lapse between administrations of the surveys presents a potential analytical weakness because GOV participants may have been influenced by information or events in the intervening years, such as the creation of the Public Health Agency of Canada [92], the reinstatement of the Canadian Population Health Initiative [93] and the implementation of a cross-sectoral government initiative to address chronic disease in British Columbia [94]. Yet, despite these key policy developments, GOV participants’ ratings of all health determinants were actually lower than the ratings from CBO participants, suggesting the lapse in timing had minimal impact on SDOH perceptions.

The different locations in which the surveys were conducted may pose an analytical weakness in the study because the responses from the two survey groups would likely have been influenced by the local contexts in which they live, work and play. What makes the findings from this study so compelling is the degree of overlap in SDOH perceptions between these groups in spite of their tremendous demographic, organizational and geographical differences.

Finally, it is difficult to know whether participants interpreted the survey questions the same way. This limitation partly stems from the ambiguity of the PHAC’s list of SDOH [5], but it also underscores the need for qualitative research to answer these deeper questions about how the determinants are conceptualized [95]. That SDOH-related policy discourse has been most prominent at the federal level in Canada [5, 96], and the fact that overlap in perceptions was observed between the two groups, suggests that they did have comparable interpretations of the survey questions.

Conclusions

This paper reports on a reasonably high degree of comparability in how the SDOH were perceived by individuals working in community-based organizations and municipal governments in two urban regions of Canada. Both groups identified the same determinants as having high, moderate and lower influence and priority for action, foreshadowing the types of interventions that these local actors would support or oppose. These findings suggest that the SDOH discourse has permeated the thinking of geographically distant groups in Canada in very similar ways and suggest that SDOH-related perceptions may be even more comparable between these groups within the same geographical boundaries. Further research, however, would be needed to confirm that this is the case.

The findings from this study deliver mixed messages for reducing population health inequities at the local level in Canada. On the one hand, the convergence of SDOH perceptions between these groups holds promise for collaborative partnerships to address the determinants of health by involving municipal governments and the non-profit sector because it suggests a shared strategic vision between these groups is possible [97, 98]. On the other hand, the types of interventions that would likely be supported by these groups (i.e. lifestyle-related) are unlikely to be effective at reducing inequities in health and indeed may have the opposite effect. If convergences in perceptions are possible and inter-sectoral collaborations are inevitable, then moving a health equity action agenda forward at the local level will require researchers to raise the profile of those determinants that can more effectively redress health inequities in a manner that captures the attention of politicians, policy makers and service providers at all levels in Canada.

Funding

The CBO study portion of this work was supported by the Centre for Health Economics & Policy Analysis at McMaster University in Hamilton, Ontario. The GOV study portion of this work was supported by the Michael Smith Foundation for Health Research (ST-SGS-405(04-1) POP) in Vancouver, British Columbia, and the Social Sciences and Humanities Research Council of Canada (752-2007-2334).
Acknowledgements

The author would like to acknowledge the generous support of her graduate study supervisors, Drs Julia Abelson, Michael Hayes and Jim Dunn, whose mentorships have all been instrumental in the development of this manuscript. She would also like to thank the Polinomics group at McMaster University for helpful comments on an earlier draft of this manuscript. Finally, the author would like to thank the reviewers for critical and insightful feedback on earlier versions of this manuscript.

Conflict of interest statement

None declared.

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