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Case No. 2, Day 1
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Learning Objective: Describe why Canadians readily acknowledge structural inequality but Americans are reluctant

Why Has the United States Failed to Acknowledge the Role of Social Determinants in Public Health Outcomes Compared to Canada?

Abstract: The Canadian public health establishment's prominent efforts to address and acknowledge the social determinants of health contrast with modest approaches seen in the United States. Since the 1970s, Canadian public health professionals have been engaged in research and even shaping international efforts to rethink strategies to promote health by tackling root socioeconomic causes. By comparison, the U.S. public health establishment is only now acknowledging the significance of social determinants and developing efforts to improve social inequities linked to human health outcomes. Deeply rooted cultural and market conditions explain some differences in both countries. The role of special interests in shaping the dialogue on U.S. national health reform has left a public legacy that still frames how experts and the middle-class public see health care outcomes as tied to personal responsibility and lifestyle issues, both strongly linked to the U.S. tradition of individualism.

Two Nations, Two Perspectives:

In June 2010 in Toronto, the Canadian Public Health Agency (CPHA) celebrated 100 years of achievements at a large expo that highlighted Canada's top 12 public health accomplishments. Two of the feted milestones were "acting on the social determinants of health" and "universal policies," which the CPHA called social welfare programs that "helped Canadians maintain a high standard of living and of health."[1] Nine of Canada's successes, like fluoridation of drinking water, also can be found the U.S. Centers for Disease Control and Prevention's (CDC) list of the 10 public health accomplishments of the last century. But, the CDC does not mention social determinants or "universal polices."[2] Nor has the CDC organized a major public event, with high-level officials, to celebrate U.S. achievements in social welfare-driven health actions. Though the American Public Health Association (APHA) has addressed the topic in many events and newsletters during the last decade, fact sheets are buried deep in its web site that a key issue for health reform is backing policies that support the "government's obligation to address social, economic, and political determinants of health."[3]

Successes achieved in Canada focusing on social determinants may be one reason the CPHA today is calling for actions that "tackle the inequitable distribution of power, money, and resources"[1] and why the Public Health Agency of Canada (PHAC) devotes significant attention in its published materials to those determinants.[4] Numerous studies have shown the health gap between the two neighbors. Overall, Canadians are doing better. They live longer. There is a lower rate of infant mortality.[5] A 2010 comparative study found, on average, Canadians were healthier than their U.S. neighbors in terms of life expectancy and other quality of life measurements, likely because of Canadians' universal health coverage and lower levels of social and economic inequality.[6] In short, social determinants are well documented in data on cross-border health discrepancies.

Leadership at the Top:

During the last four decades, the Canadian health establishment has taken a stronger policy and research approach to tackling social determinants of health than its U.S. cousin. In fact, Dennis Raphael (2003), a leading researcher in the field, calls Canada a world leader in developing the implications of research on the social determinants of health.[8] In 1974, the Government of Canada (GOC) released a health study known as the Lalonde Report, which linked health and illness as determined by human biology, environment, lifestyle, and health care organization. It was a milestone for singling out determinants other than the health care system and helped the CPHA to take a leadership role in Canadian public health.[9] It is doubtful that in the health department in this case anyone had even heard of this report or understood its significance.

Since the 1970s, Canadian policy-makers and researchers, unlike their U.S. counterparts, have been continuously exposed to and focused on ideas about non-medical determinants of health.[10] As a result, federal, provincial, and local health departments organized population health divisions, though the evidence is not conclusive that the ideas have influenced other branches of

government in Canada at the policy-making level or that the Canadian public has an awareness of the importance of the social determinants of health.[8] In fact, Raphael (2003) claims that policy-makers in Canada are taking actions to weaken the welfare state and the social determinants of health.[8] (However, this paper will not explore that claim.)

At the international level, Canadian experts took a key role in showing the importance of social determinants to human health. The Ottawa Charter for Health Promotion was launched in Canada in 1986 at a conference organized by the World Health Organization (WHO) and the CPHA and Health and Welfare Canada. The document acknowledged role of social determinants in basic health and to health promotion and called for advocacy in the health arena that would improve political, economic, social, and cultural conditions for all people.[11] Canadians reached another milestone in 1999, when the GOC released a report called *Towards a Healthy Future: Second Report on the Health of Canadians*, which brought together the latest research on the health of Canadians, looking at social determinants including income, income distribution, education and literacy, unemployment, working conditions, and other factors.

Cultural Differences and 'American Exceptionalism':
Numerous researchers claim the United States' failure to embrace social reforms to boost health outcomes, like a government-backed universal health scheme, stems from "American exceptionalism." Seymour Lipset notes that the "American creed" that celebrates liberty, individualism, and laissez-faire has steered the country from the welfare model of Western Europe. America, he says, remains more individualist, meritocratic, and anti-statist than other nations, with a weaker tradition for socialist movements than the industrialized world. By comparison, Canadians "have much greater respect for and reliance on the state."[13] Thus, any government action to extend narrow welfare benefits to the general U.S. populace evokes charges of an overreaching state.[14] Such charges were leveled repeatedly during the 2009-10

debates over U.S. health insurance reform. Another commentator, Sven Steinmo, claims that despite the U.S. welfare state tradition of the New Deal and the Medicaid and Medicare programs, the U.S. Constitution made it harder for socialist and leftist political parties to gain power, prohibiting the development of universalistic welfare policies seen in Western Europe.[15]

Some also point to key historic markers in Canada. Canadians belief in government involvement has been linked to the 1867 Constitution Act that lays out Canada's founding principles of "peace, order, and good government." The act is referenced as an inspiration for public-health oriented collective action in Canada by the CPHA.[11] This could explain the Canadian professional community's willingness to accept state interventions addressing social inequity as a means of tackling health issues.

Polling on attitudes to government and social policy backs such cultural-deterministic claims. The Pew Center (2004) found that more than 6 in 10 Canadians and Americans share very similar views that people determine their own success in life, and 7 in 10 of both thought that government should care for the poor. However, 58 percent of Americans polled believe that freedom to pursue their life's goal was more important than assuring no one was in need, compared to 43 percent of Canadians.[16]

Other cultural-determinist research has shown that the U.S. and Canadian approaches are modeled on two different models of justice.[17] The market model assumes health care is a scarce resource and is given as a reward for individual success, while the social model assumes medical care is a social good and universal right, managed by government. Leiyu Shi and Douglas Singh say the U.S. medical system, largely private and driven by a medical model of care, "can be traced back to the beliefs and values underlying the American culture."[17]

Still others reject the such explanations and offer a "stakeholder mobilization" model that

recognizes that health institutions, like U.S. hospitals and Blue Cross insurance, and special

interests groups, like the American Medical Association (AMA), played a large role in shaping

U.S. attitudes to health care during Congressional battles that shelved plans for universal health

care in the 1940s and 1990s.[18] David Rothman shows that the explosive growth of Blue Cross by

1954, when 60% of the American population had health insurance from the marketplace, was

tied to hospitals becoming the primary form of health delivery. During debates over President

Truman's national health insurance plan, Blue Cross's media campaign, backed by hospitals

promoting technological medical care, convinced the middle class that the "American way" to

deliver health care was via the private, not public, sector.[19] Steinmo also notes that during those

debates of the 1940s, a media campaign financed by the American Medical Association (AMA)

helped tag a government-run health plan as "un-American" by calling it "socialized medicine."[15]

Back to the Case and Questions:
   As seen in this case over the health divide, the public health communities on opposite sides of

the Canada-U.S. border have differing levels of understanding of how social determinants impact

health, with the U.S. professionals seemingly less aware or unwilling to promote policies aimed

at correcting social inequities. The gap has numerous origins, historic and cultural, but is also

related to actions taken in those health communities, by public health professionals in Canada's

case, and, in the United States' case, on a national stage by well-financed, powerful interest

groups with a financial stake in the outcomes of proposed federal legislation.

1. Would a public relations campaign in the United States similar to that launched by the CPHA

help raise awareness of the social determinants of health within the U.S. public health sector?

2. How can studies be designed to measure whether such broad public health awareness

campaigns, as Raphael claims in Canada's case, are working, or not, with an "all of government

approach."

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