

## DEBATES

# The political economy of health promotion: part 1, national commitments to provision of the prerequisites of health<sup>†</sup>

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### SUMMARY

Canada is a leader in developing health promotion concepts of providing the prerequisites of health through health-promoting public policy. But Canada is clearly a laggard in implementing these concepts. In contrast, France is seen as a nation in which health promotion concepts have failed to gain much traction yet evidence exists that France does far better than Canada in providing these health prerequisites. Such findings suggest that it is the political economy—or form of the welfare state—of a nation rather than its explicit commitments to health promotion concepts—that shape provision of the prerequisites of health. Part 1 of this article examines how health promotion rhetoric specifically concerned with provision of the prerequisites of health differs among nations

identified as being either liberal, social democratic, conservative or Latin welfare states. Governing authorities of nations that are liberal or social democratic welfare states are more likely to make explicit rhetorical commitments to provision of the prerequisites of health, the conservative and Latin states less so. Part 2 of this article provides evidence however, that despite their rhetorical commitments to provision of the prerequisites of health, liberal welfare state nations fall well behind not only the social democratic nations, but also the conservative welfare states in implementing public policies that provide the prerequisites of health. The Latin welfare states express little commitment to provision of the prerequisites of health and rather limited public policy activity towards meeting this aim.

*Key words:* government programmes; health policy; public health

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### INTRODUCTION

Canada has come to be seen as a leader in developing health promotion concepts that emphasize the importance of providing the prerequisites of health (i.e. peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity) through health-promoting public policy (i.e. complementary approaches including legislation, fiscal measures, taxation and organizational change) (World Health Organisation, 1986). Yet, Canadian governmental authorities have been

repeatedly identified as laggards in implementing these concepts through public policy activity (Raphael, 2008a; Senate Subcommittee on Population Health, 2009; Health Council of Canada, 2010; Bryant *et al.*, 2011).

Along similar lines, Australian and English governing authorities are also seen as providing leadership in health promotion (Health Council of Canada, 2010), yet evidence indicates they do far worse in providing the prerequisites of health than nations such as France, Belgium and Germany where governmental health promotion commitments are less apparent

(Organisation for Economic Co-operation and Development, 2011). As one example, France is a nation where health promotion concepts have failed to gain traction among governmental authorities (Lang *et al.*, 2003; Guillaumie, 2007), yet France does far better than Canada—and perhaps Australia and England—in providing its citizens with these prerequisites of health (Organisation for Economic Co-operation and Development, 2011).

Such contrasts between rhetoric and action has led to my thinking that it is the political economy of a nation—the general organization of its economic and political systems—rather than governmental authorities' explicit commitments to the provision of the prerequisites of health through health promotion activities that determines whether citizens are provided with these prerequisites (Raphael and Bryant, 2006). What are some of the features of these differing political economies that would support such a hypothesis?

The political economies—or form of the welfare state—of wealthy Western nations cluster into four general welfare regimes: the social democratic, conservative, Latin and liberal (Esping-Andersen, 1990; Esping-Andersen, 1999; Saint-Arnaud and Bernard, 2003). The social democratic welfare states are distinguished by their strong commitments to State provision of citizen economic and social security—a concept that appears closely related to provision of the prerequisites of health—while the liberal welfare states generally rely upon the economic marketplace to distribute economic and social resources. The conservative and the less extensively developed Latin welfare states are distinguished by their emphasis upon social insurance programs that reduce economic and social risks among wage earners. Evidence suggests a continuum of State support of citizens from stronger to weaker as follows: social democratic—conservative—Latin—liberal (Esping-Andersen, 1999; Saint-Arnaud and Bernard, 2003; Eikemo and Bambra, 2008).

Interestingly, the nations that fall at the opposite ends on this citizen support dimension, the liberal (e.g. Canada, Australia and England) and social democratic welfare states (e.g. Norway, Sweden and Finland) are those whose explicit governmental commitments to the prerequisites of health through health promotion activities are strongest (Raphael and Bryant, 2010). But at the same time, the implementation of these concepts in public policy appears to differ widely with the

social democratic welfare state nations doing rather well, the liberal welfare states less so (Navarro and Shi, 2002; Navarro *et al.*, 2004). The strength of these rhetorical health promotion commitments among governing authorities—and their policy activities—in nations identified as conservative (e.g. Belgium, France and Germany) and Latin (e.g. Greece, Italy and Spain) welfare regimes have been less examined.

In this two-part article, I explore these issues by examining the intersections among the presence or absence of explicit governmental commitments to provision of the prerequisites of health through health promotion activities, the public policy activities that support such provision, and a nation's welfare state type. I coin the phrase 'explicit health promotion commitments' to refer to rhetorical commitments of governing authorities that endorse—within a health promotion framework—provision of the prerequisites of health. These explicit health promotion commitments should also endorse the importance of developing health-promoting public policy that provides the prerequisites of health. Ideally, these explicit commitments should be followed by 'explicit health promotion policy activities' that address these issues.

I also coin the phrase 'implicit health promotion activity' to refer to public policy efforts that provide the prerequisites of health but do so in the absence of explicit commitments made within a health promotion framework. In the implicit health promotion activity case, health promotion statements are less salient—or even absent—but existing public policy approaches are consistent with the health promotion principle of providing the prerequisites of health. An examination of these public policy activities constitutes the main content of Part 2 of this article.

These distinctions between explicit commitments and implicit activities are important because those concerned with health promotion will be more likely to be involved in activities that have been clearly identified as falling within their domain of expertise. If public policy activities that address provision of the prerequisites of health are clearly situated within a health promotion framework then the expertise and involvement of health promoters should be seen by governing authorities and the public as necessary to these efforts. In contrast, if health prerequisite strengthening activities are not explicitly identified as health promotion activities, health promoters' involvement may not

**Table 1:** Proposed intersections of commitments and policies towards provision of the prerequisites of health with nations' form of the welfare state

Explicit commitment to provision of the prerequisites of health within a health promotion framework <sup>a</sup>			
Yes		No	
Public policy efforts towards provision of the prerequisites of health			
Extensive	Undeveloped	Extensive	Undeveloped
Social democratic <sup>b</sup> Welfare states	Liberal Welfare states	Conservative Welfare states	Latin Welfare states

<sup>a</sup>Judgements of explicit and implicit commitments and policies based on published reviews of national profiles.

<sup>b</sup>Welfare state designation based on Saint-Arnaud and Bernard (2003).

be seen as relevant by governing authorities and the public and therefore will be neither solicited nor encouraged.

I expect that the governing authorities of nations identified as social democratic and liberal welfare states will be more likely to express explicit commitments to provision of the prerequisites of health within a health promotion framework. I also expect that nations identified as social democratic and conservative welfare states—based on their commitments to the provision of citizen economic and social security—will devote rather more policy attention to provision of the prerequisites of health than nations identified as liberal and Latin welfare states. Table 1 outlines the proposed intersections of health promotion approach, extent of public policy activities towards the prerequisites of health and a nation's form of the welfare state.

If these intersections are found to be accurate, two important questions arise for health promoters:

- What are the implications of a nation's placement in the welfare state regime typology for health promoters concerned with provision of the prerequisites of health through public policy activities?
- What are the implications for health promoters' efforts of the presence or absence of explicit health promotion commitments to provision of the prerequisites of health by governmental authorities through public policy activities?

## HEALTH PROMOTION AND THE PREREQUISITES OF HEALTH

In this article, the focus is on 'health promotion' as defined by the World Health Organisation

(WHO) (World Health Organisation, 1986) as distinguished from traditional public health concerns of health protection (Nutbeam, 1998). Health promotion as outlined by the WHO represents a commitment to improve health and wellbeing through societal change. This concept of health promotion—not to be confused with its narrow incarnation focused on behavioural change—has its origins in structural analyses of health issues derived primarily from the social sciences (MacDonald and Davies, 1998; Bunton and MacDonald, 2002). Three key principles of health promotion that can be abstracted from the Ottawa Charter for Health Promotion are as follows: (i) political and economic structures that provide the prerequisites of health should be strengthened; (ii) individuals and communities can undertake activities to increase their control over the determinants of health and (iii) these thrusts should combine to create healthy public policy that is responsive to the needs of the citizenry.

In line with its predominantly structural approach to promoting health, the Ottawa Charter outlines prerequisites of health of peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity (World Health Organisation, 1986). Each international health promotion conference to the present has reaffirmed the importance of the prerequisites of health—now frequently spoken of as the social determinants of health—and the public policy that provides these prerequisites (World Health Organisation, 2009).

Health-promoting public policy that provides these prerequisites of health includes legislation, fiscal measures, taxation and organizational change (World Health Organisation, 1986). The importance of public policy is also a key component of the work done by the

Commission on Social Determinants of Health (World Health Organisation, 2008). In Canada, the Canadian Public Health Association sees public policy that strengthens the determinants of health as the best means of promoting health (Canadian Public Health Association, 1996).

What are some examples of public policy that support the prerequisites of health? Extensive overviews of the public policy antecedents of all the prerequisites of health are available (World Health Organisation, 2008; Raphael, 2009), but Table 2 provides a flavour of these policies through a sampling of the relationships between public policy and three important prerequisites of health that have been the primary focus of both prerequisites and social determinants of health activity: early child development, employment and income (Irwin *et al.*, 2007; Wilkinson and Pickett, 2009; Benach *et al.*, 2010).

In practice, however, there is wide disparity in the take-up and application of these principles across national jurisdictions (Raphael and Bryant, 2010). Health promotion activities in the wealthy developed English-speaking jurisdictions, while working with policy statements and documents that recognize the importance of public policy that provides the prerequisites of health, have emphasized modifying health-related risk behaviours (Raphael, 2008a; Wills *et al.*, 2008; Wise, 2008). This has especially been the case in North America (Hofrichter, 2003; Raphael, 2008b).

In Europe there has been greater focus on the development and implementation of public policy that provides the prerequisites of health (Mackenbach and Bakker, 2003; Hogstedt *et al.*, 2008). The Scandinavian nations have been identified as both adopting the rhetoric of health promotion and implementing its key principles in public policy activities, the Continental nations less so. But this latter conclusion may be deceiving. While explicit health promotion rhetoric may be less apparent in Continental nations' policy statements and documents than in the Scandinavian nations, in many respects public policy appears to be aligned with the important health promotion principle of providing the prerequisites of health (Olsen, 2002; Pontusson, 2005). The real distinction may be between the English-speaking nations and European nations. There is evidence that these differences in providing the prerequisites of health are associated with variations in important health outcomes (Navarro and Shi, 2002; Navarro *et al.*, 2004; Bamba, 2006).

**Table 2:** Public policies that influence three key prerequisites of health

Prerequisite	Public policy influences
Early life	<p>Policies that assure provision of adequate income to families either through universal benefits, sufficient wages for those inside the work force or assistance levels for those outside the work force.</p> <p>Policies that provide affordable, high-quality childcare and early education and benefits to families with children.</p>
Employment and working conditions	<p>Policies that enable collective bargaining and agreements (e.g. regulations that facilitate trade union activity, presence of intersectoral bargaining and agreement coordination).</p> <p>Policies that require provision of benefits to part-time and temporary workers commensurate to that provided to full-time employees.</p> <p>Policies that provide training and retraining programs (active labour policy).</p>
Income and income distribution	<p>Policies as described above with additional policies that create more progressive taxation policy that narrows the gap between the top and bottom.</p> <p>Policies that prove greater decommodification of supports and services such as pensions, employment and sickness benefits and resources such as education, recreation, housing and other necessities.</p>

In wealthy developed capitalist nations, the State, in the form of governmental public policy-making can intervene to influence how the marketplace distributes economic resources amongst the population. Frequently, these decisions to manage the economy and its effects are the result of particular political forces that are accompanied by dominant ideological discourses. In social democratic and conservative nations, these interventions in the operation of the economy are common. In liberal and Latin welfare states, such interventions are less common. Examples of some of these prerequisites of health-related areas that indicate State intervention in the operation of the market economy are presented in the table.

Sources: Irwin *et al.*, 2007; Wilkinson and Pickett, 2009; Benach *et al.*, 2010.

These contrasts among English-speaking, Scandinavian and Continental nations in health promotion activity and outcomes appear to represent differences in their political economies—

that is the interplay between the economics and politics of a nation—and how these economies provide various forms of citizen economic and social security (Raphael and Bryant, 2006). If this is the case, two key questions arise: How do these differences in political economies lead to the adoption of differing approaches to health promotion? What are the implications for health promoters who wish to strengthen the prerequisites of health through public policy activity?

## THE POLITICAL ECONOMY OF THE WELFARE STATE

Recent literature has considered different political economies within a ‘worlds of welfare’ framework that distinguishes between differing forms of the welfare state (Bambra, 2007; Eikemo and Bambra, 2008). In this framework, varied public policy components fit together to define a specific welfare state regime. Esping-Andersen identifies three regimes of welfare capitalism: social democratic, conservative and liberal to which Saint-Arnaud and Bernard add a fourth Latin type (Esping-Andersen, 1990, 1999; Saint-Arnaud and Bernard, 2003). Bambra (2007) identifies no less than 12 different welfare state typologies but virtually all make a distinction between liberal or residual and social democratic or encompassing types with a mid-level type that usually corresponds to the conservative form. The Scandinavian, Continental—including Latin—and English-speaking nations mentioned above appear to correspond to social democratic, conservative and liberal political economies, respectively. Esping-Anderson sees these differing regimes as resulting from distinctive political and social histories (Esping-Andersen, 1990).

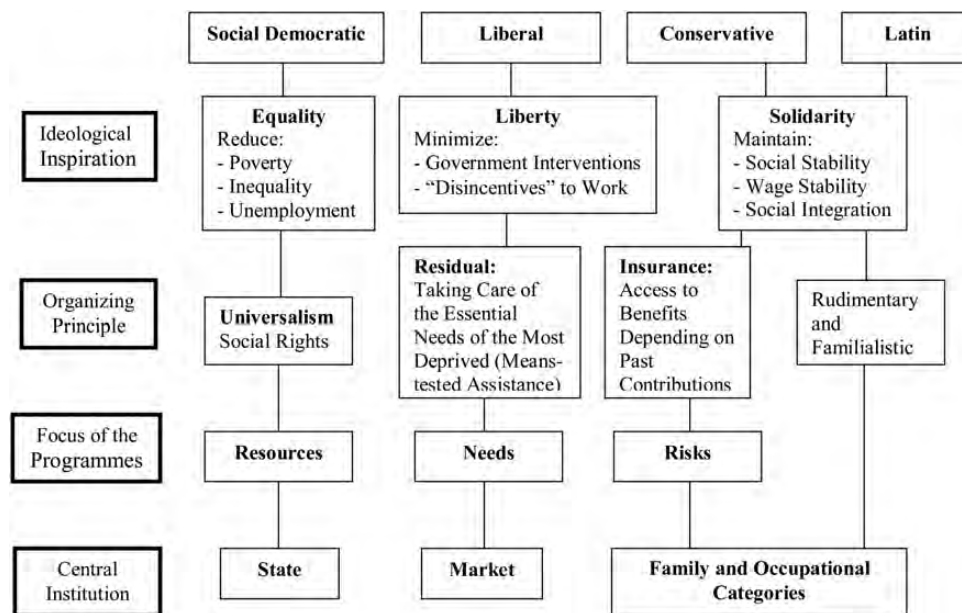
The social democratic welfare states (e.g. Finland, Sweden, Denmark and Norway) emphasize universal welfare rights and provide generous benefits and entitlements. Their political and social history is one of political dominance by social democratic parties of the left, a result of political organization of initially industrial workers and farmers, and later the middle class. Through universal provision of a range of benefits, these regimes have been able to secure the loyalties of a significant proportion of the population (Esping-Andersen, 1990, 1999).

Conservative welfare states (e.g. Belgium, France, Germany and Netherlands) also offer generous benefits but provide these based on social insurance plans associated with employment status with emphasis on primary male wage earners. Their political and social history is one of political dominance by Christian Democratic parties where traditional Church concerns with supporting citizens merges with traditional approaches towards maintaining status differences and adherence to authority (Esping-Andersen, 1990, 1999). These tendencies sometimes manifest in corporatist approaches (e.g. Germany) where business interests are major influences or in Statist approaches (e.g. France) where the State plays a key role in provision of citizen security (Pontusson, 2005).

Liberal welfare states (e.g. Australia, Canada, UK and USA) provide modest benefits and the State usually steps in with assistance only when the market fails to meet citizens’ most basic needs. Their political and social history is one of dominance by business interests that has led the population to give its loyalty to the economic system rather than the State as a means of providing economic and social security (Esping-Andersen, 1990, 1999). These liberal welfare states are the least developed in terms of provision of citizen economic and social security. A key feature is their use of means-tested benefits that are targeted only to the least well-off.

Latin welfare states (e.g. Greece, Italy, Spain and Portugal) are identified by Saint-Arnaud and Bernard (2005) as less developed family-oriented versions of the conservative welfare regime. While there has been extensive debate about the value of the worlds of welfare typology (Bambra, 2007), recent analyses provide strong evidence of their validity (Saint-Arnaud and Bernard, 2003). Figure 1 identifies key elements of each of these four forms of the welfare state (it should be noted that some nations are more centralized in their health policy-making such as Sweden and England, while others are decentralized such as Germany, Italy and Canada. These differences do not appear to have a determining influence upon the primary issues of the provision of the prerequisites of health through health-promoting public policy).

There are clear affinities between the health promotion principle of providing the prerequisites of health as defined by the WHO (i.e. peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice



**Fig. 1:** Ideological variations in forms of the welfare state. *Source:* Saint-Arnaud and Bernard, 2003, Figure 2, p. 503.

and equity) and aspects of these differing forms of the welfare state. The liberal welfare state with its emphasis on minimizing State intervention in the operation of the marketplace and provision of minimal benefits appears to be the least likely to produce public policy that provides the prerequisites of health. The social democratic and conservative welfare states—with their emphasis on promoting equality in the former case and solidarity in the latter—should be more likely to implement public policies that provide the prerequisites of health. Little has been written about how the Latin welfare states may provide the prerequisites of health except to point out their relatively undeveloped nature and their emphasis upon the family as providing the primary means of support (Navarro and Shi, 2001; Saint-Arnaud and Bernard, 2003). Therefore, they may be expected to provide to a lesser extent the prerequisites of health than the social democratic and conservative welfare states.

Evidence exists that this is the case. State provision to citizens of economic and social supports appears to lag among liberal welfare states with the greatest differences seen between the social democratic and liberal welfare states (Navarro and Shi, 2002, Navarro *et al.*, 2004, Bambra, 2006). In this article, these

findings are updated, and additional indicators are compared. The situation in the Latin welfare states is carefully examined. Most importantly, all of this is done in conjunction with analysis of the health promotion scenes in selected exemplars of these differing welfare states. By situating health promotion activities within the context of the political economy of the welfare state, the implications for health promoters of differing forms of the welfare state and the presence or absence of explicit health promotion commitments can be identified.

## METHODOLOGY

This examination of the intersection of health promotion activities with political economies focuses on the forms health promotion has taken in the liberal welfare states of Australia, Canada and England (the USA is not examined since it is such a negative outlier in its health promotion and public policy approaches to the provision of the prerequisites of health, Raphael (2008b)); the social democratic welfare states of Finland, Norway and Sweden (Denmark provides an interesting case where a well-developed welfare state that appears to be committed to the prerequisites of health, yet lacks a rhetorical health

promotion commitment to these concepts and shows rather poor health outcomes); the conservative welfare states of Belgium, France and Germany (The Netherlands is not included in this study since its efforts in reducing health inequalities has been extensively reported with rather less attention given to the three nations chosen), and the Latin welfare states of Italy, Greece and Spain (Portugal is not included primarily because of a lack of literature concerning their health promotion efforts). These nations are all clearly situated within their respective welfare state groupings according to a detailed empirical analysis of the range of their public policies in a variety of prerequisite-related areas (e.g. overall public transfers to citizens, laws related to financial and social support to citizens and expenditures on social infrastructure such as education and health care) (Saint-Arnaud and Bernard, 2003).

Australia, Canada and England were chosen since their contributions to the health promotion literature are apparent yet they are clear examples of liberal welfare states that limit their support for the prerequisites of health through public policy activity (Esping-Andersen, 1999; Saint-Arnaud and Bernard, 2003; Eikemo and Bambra, 2008). Finland, Norway and Sweden are clear leaders in both expressing ideological commitments to the provision of the prerequisites of health and in developing public policy in support of these aims.

Belgium, France and Germany are excellent examples of conservative welfare states whose explicit health promotion commitments are less apparent yet evidence suggests provide prerequisites of health supportive public policy. Greece, Italy and Spain are examples of the Latin welfare state, which lacks a health promotion emphasis and manifests as an undeveloped form of the conservative welfare state. Characteristics of not-selected members of these welfare state regimes—the USA and New Zealand (liberal), Denmark (social democratic), Netherlands and Switzerland (conservative) and Portugal (Latin)—can be seen in the broader analysis reported in Part 2 of this article.

### Search of the literature

This article relies on literature that is available in English. It is important to note that the liberal and social democratic welfare state nations' documents and statements about

provision of the prerequisites of health are widely available in English, the conservative and Latin welfare state nations rather less so. More specifically, the preparation of this article involved a systematic search of all articles published in the last 10 years in *Health Promotion International*, *Promotion and Education* (now *Global Health Promotion*), *Critical Public Health* and *Social Science and Medicine* as well as through Google Scholar identified by the keyword 'health promotion' and the national identifier of the specific nation. This search showed a preponderance of articles in the English-language literature by authors from Australia, Canada and the UK. There were virtually no articles available in English that explicitly spoke about the conservative or Latin welfare state approach towards provision of the prerequisites of health within a health promotion framework.

Literature searches using these keywords, however, identified some key texts which contained national case studies in English concerned with either health promotion or health inequalities. Three key sources are the volume *Reducing Inequalities in Health: A European Perspective* (Mackenbach and Bakker, 2002), *Health for All? A Critical Analysis of Public Health Policies in Eight European Countries* (Hogstedt *et al.*, 2008), and the national case reports provided by the European Portal for Action on Health Equity. The Portal is part of the European Union Consortium for Action on Socio-economic Determinants of Health which is concerned with reducing health inequalities through action on the social determinants of health (DETERMINE, 2010a). When national reports and documents were available in English, these were reviewed.

### Identification of explicit or implicit approaches

The finding of *explicit health promotion commitments* can be seen when some or all of the following governmental or health sector rhetoric is present: (i) statements about the importance of providing the prerequisites of health through public policy activity; (ii) statements about promoting health through community-level activities or (iii) statements about promoting health through individual behaviour change related to 'healthy living' or healthy lifestyle choices. These levels represent macro-, meso- or micro-level approaches to health promotion and

may or may not be accompanied by actual activities that implement these goals. In this article, the focus is on health promotion rhetoric at the macro-level ‘a’.

*Implicit health promotion activity* is seen where governmental policies serve to provide the prerequisites of health but these are not explicitly identified as health-promoting public policy and is the focus of Part 2 of this article. These policies include: (i) processes that enable the negotiation of collective employment agreements that provide a modicum of employee rights and benefits; (ii) governmental and institutional activity that manages the extent of income inequality and poverty within a jurisdiction; (iii) governmental and institutional activity that promotes employment training and reduces unemployment (active labour policy) and (iv) governmental and institutional activity that meets early child development needs of citizens, among others.

### **POLICY STATEMENTS AND ACTIVITIES CONCERNED WITH HEALTH PROMOTION**

This overview, based on previously published documents, has the modest aim of providing an evaluation of how governmental commitments to the prerequisites of health and related public policy activity intersect with form of the welfare state. The 12 brief overviews of national *explicit health promotion commitments* that follow identify the extent to which there are governmental commitments to provision of the prerequisites of health within a health promotion framework. There will be some reference to public policy activity that is related to provision of the prerequisites of health but the bulk of the analysis of these activities occurs in Part 2 of this article. Focus is therefore on the extent to which national policy statements on provision of the prerequisites of health are placed within a health promotion framework. This would include the situation where prerequisites of health issues are embedded within a concern with ‘reducing health inequalities’ (DETERMINE, 2010a).

These overviews are for the most part based on national situations prior to the onset of the 2008 global recession. And the most recent data related to the public policy indicators presented in Part 2 of this article are from 2007 to 2008. There is no doubt that public policy since then

has been influenced by this as well as changes in electoral outcomes in many nations. But these overall effects are probably minor in terms of the profiles presented here and findings presented in Part 2 of this article since research has found that:

[W]elfare states are highly resistant to pressures attendant to international and domestic structural socio-economic change (e.g. internationalisation, deindustrialisation, and ageing). Incumbent governments find it very difficult to reduce concentrated benefits to well-defined, mobilised constituencies in return for future, diffuse benefits. Generally, welfare states are path dependent in that the cognitive and political consequences of past policy choices constrain and otherwise shape efforts at programmatic and systemic welfare retrenchment (Swank, 2005, p. 187).

### **Australia**

Australia has produced numerous policy documents that address the issues of health inequalities and the social determinants of health (Health Council of Canada, 2010). It has done so by emphasizing the importance of promoting health equity—reducing inequalities in health that are unfair and avoidable—and strengthening the social determinants of health. Until 2006, these activities were focused in Australian state governments with rather little activity by the federal government (Newman *et al.*, 2006), but the election of a federal labour government in 2007 has seen the development of a Social Inclusion Initiative that shares some affinities with this state-level work (Macdonald, 2010).

With regard to state-level activity, the documents and policy statements from New South Wales, Victoria, South Australia and Tasmania are especially impressive (see Health Council of Canada, 2010 for a recent review). As an example, The New South Wales Department of Health document, *In all Fairness* (Department of Health—New South Wales, 2004b), contains a health and equity statement that provides direction for planning, a resource distribution and funding formula that provide guidance on how to allocate resources on eight health areas on the basis of population numbers and extent of deprivation or disadvantage, as well as research to create new knowledge on the causes and means of addressing health inequalities. A New South Wales Public Health Bulletin expanded upon that document to identify the need to ‘work with the community, non-government



organizations and other government departments, to influence those things we know affect health—a good education, secure employment, safe communities and access to affordable accommodation, food and transport’ (Department of Health—New South Wales, 2004a, p. iii).

MacDonald (2010) argues that the 2008 Social Inclusion Initiative of the federal government—which appears to be similar to the UK social exclusion initiative—while not using the expression social determinants provides recognition that political, social, economic and cultural contextual factors influence health. Specifically, the federal government adopted a set of principles—developed by the Australian Social Inclusion Board—to guide the Social Inclusion Agenda. The aspirations of the Initiative are to ‘reduce disadvantage, increasing social, civic and economic participation and develop a greater voice, combined with greater responsibility’. Some of the health-related activities to accomplish this are building partnerships with key stakeholders; giving high priority to early intervention and prevention; building joined-up services and whole of government (Keskimäki *et al.*, 1997) solutions and using evidence and integrated data to inform policy (Government of Australia, 2011). MacDonald (2010) believes this represents ‘the need to adopt policies to tackle health inequalities through the social determinants of health’ (p. 37). Other health researchers take a similar view with regard to a related initiative by the South Australia state government (Baum *et al.*, 2010).

## Canada

For decades, Canadian governmental and professional associations have argued the importance of the determinants of health and healthy public policy (Legowski and McKay, 2000; Collins and Hayes, 2007; Low and Theriault, 2008). The federal government’s *A New Vision of Health for Canadians* identified four fields that determined health: human biology, lifestyles, environment and health care (Lalonde, 1974). The identification of the environment field has been seen as signalling the beginning of a broader health promotion era which saw its realization in the Ottawa Charter’s definition of health promotion.

Similarly, the federal government’s 1986 document *Achieving Health for All: A Framework for Health Promotion* identified the

importance of providing the prerequisites of health through the coordination of healthy public policy (Epp, 1986). It declared: ‘All policies which have a direct bearing on health need to be co-ordinated. The list is long and includes, among others, income security, employment, education, housing, business, agriculture, transportation, justice and technology’ (pp. 4,10).

More recently, the prerequisites of health concept figures prominently in Canadian health policy documents produced by the Federal government, numerous public health and social development organizations and agencies, and research funding agencies (Canadian Institute for Health Information, 2002; Institute of Population and Public Health, 2003; Health Council of Canada, 2010). Even the business-oriented Conference Board of Canada established an initiative focused on the social and economic determinants of health (Conference Board of Canada, 2008).

It has been suggested that there has been little application, however, of these concepts at either the federal or provincial levels such that Canada is now seen as being well behind other nations in applying its own concepts to promoting health (Bryant *et al.*, 2011). The Canadian Population Health Initiative—a federal government-funded research institute—noted (Canadian Population Health Initiative, 2002): ‘Canada has fallen behind countries such as the UK and Sweden and even some jurisdictions in the USA in applying the population health knowledge base that has been largely developed in Canada’ (p. 1).

Similarly, the Canadian Senate Subcommittee on Population Health carried out an extensive review of how Canada has been approaching the issues of inequalities in health and concluded in its Press Release: (Senate Subcommittee on Population Health, 2009): The subcommittee found that Canada is seriously falling behind countries such as the UK and Sweden (p. 1).

## England

England has a long-standing intellectual and academic concern with inequalities in health. The election of a Labour government in 1997—which campaigned on a platform of reducing health inequalities—saw the ongoing academic and policy concern with health inequalities translated into a government-wide effort to address health inequalities through the development of public policy.

The focus here is on England although developments in Wales and Scotland parallel these. Among the initial major policy initiatives was the document *Reducing Health Inequalities: An Action Report* (Department of Health, 1999). The government organized a strategy based on nine themes that included the following:

*Raising living standards and tackling low income* by introducing a minimum wage and a range of tax credits and increasing benefit levels.

*Improving education and early years* by introducing policies to improve educational standards, creating ‘Sure Start’ preschool services in disadvantaged areas free to those on low incomes.

*Increasing employment* by creating a range of welfare-to-work schemes for different priority groups.

*Building healthy communities* by investing in a range of regeneration initiatives in disadvantaged areas, including Health Action Zones.

*Improving housing* by changing capital financial rules to promote investment in social housing and introducing special initiatives to tackle homelessness.

Goals were set for the elimination of health inequalities. The 2002 Spending Review Public Service Agreement—a kind of business plan—for the Department of Health contained the goal of ‘By 2010 to reduce inequalities in health outcomes by 10% as measured by infant mortality and life expectancy at birth’ (UK Government, 2002). These initiatives focused on: (i) tackling poverty and low income; (ii) improving educational and employment opportunities; (iii) rebuilding local communities and (iv) supporting vulnerable individuals and families (Oliver and Nutbeam, 2003). To facilitate action, the government set up ‘cross-cutting spending reviews’ focused on health inequalities to be used by a number of departments to inform spending plans for 2003–2006.

The most striking aspect of these developments in England—and those that followed was the placing on the public policy agenda of a wide range of issues related to a structural approach to health promotion. Whitehead and Bird (2008, p. 117) comment:

Clearly, the past 10 years in England have been remarkable for the amount of feverish activity on health inequalities at all levels and the serious political commitment that this demonstrates... England now

has a semblance of a co-ordinated strategy to tackle inequalities in health, which may not be perfect, but which is a vast improvement on previous efforts.

More recently, the government—since defeated in a national election—commissioned a report to propose an evidence-based strategy for reducing health inequalities from 2010 on (Marmot *et al.*, 2010). The strategy includes policies and interventions that address the social determinants of health inequalities and lays out a plan for the next 10 years.

In all three liberal nations then, there are clear policy statements about promoting health through public policy that addresses either the prerequisites or social determinants of health. In the case of Australia and England, these statements have been paralleled by public policy activity designed to achieve these objectives. While how these nations fare in provision of these prerequisites of health is considered in Part 2 of this article, evidence suggests that in England, these efforts have born some fruit in that reductions in child and pensioner poverty occurred up until 2004/2005, and there has been a marked decline in persistent poverty and deprivation among families with children (Hills *et al.*, 2009).

## SOCIAL DEMOCRATIC WELFARE STATES

The social democratic welfare states are distinguished by policy statements that stress the important role public policy plays in promoting health through action on the prerequisites of health and their concerted public policy action that addresses these issues.

### Finland

Finnish health policy has been concerned with reducing inequalities in health since the 1960s (Palosuo *et al.*, 2008). Finland became one of the first nations to apply the *WHO Health for All by the Year 2000* program to its national scene. As early as 1986, the four general targets under the *Health for All* program included reducing health disparities between population groups, producing smaller health differences between genders, socio-economic categories and people living in different regions.

The Government Resolution on the Health 2015 Public Health Programme (2001) defined

reducing health differences between population groups as a central goal (Finnish Ministry of Social Affairs and Health, 2001). Similarly, in *Strategies for Social Protection 2010* (2001), the Finnish Ministry of Social Affairs and Health outlined preventive social policy that (i) supports growth and development of children and young people, (ii) prevents exclusion, (iii) supports personal initiative and involvement among the unemployed and (iv) promotes basic security in housing. Promoting lifelong learning, wellbeing at work, increasing gender equality and social protection, and giving priority to preventive policy, early intervention and actions to interrupt long-term unemployment and providing adequate income security were key processes to accomplish this.

The Finnish Government Resolution on the Health 2015 Public Health Programme (2001) concluded that progress had been made on these health goals. More recently, the Minister of Health Paula Risikko has commented:

The goal of reducing health inequalities is explicitly mentioned in both the 2003 and 2007 Finnish Government Programmes. The 2006 Social and Health Report to the Parliament also identified the reduction of health inequalities and the prevention of marginalisation as key challenges for the future. In its strategy document for social and health policies (Strategies for Social Protection 2015), the Ministry of Social Affairs and Health identifies the reduction of health inequalities as a major target in the promotion of the population's health and functional capacity (Palosuo *et al.*, 2009, p. 5).

Palosuo *et al.* (Palosuo *et al.*, 2008) point out that a quantitative target of reducing health inequalities—defined as differences in death rates among genders, those of differing educational levels and of differing occupation status—of 20% by the year 2015 has been set.

## Norway

Norway has a history of emphasizing a structural approach to promoting population health and reducing health inequalities (Fosse, 2008). In 1984, a Norwegian Government White Paper adopted the World Health Organisation's *Health for All 2000 Strategy* and provided a specific commitment to reduce social inequalities with a strong emphasis upon health-in-all public policy areas. Since then a series of documents further developed Norway's approach. The 2003

Government White Paper entitled *Prescriptions for a Healthier Norway*, called for (i) interventions to influence lifestyles will be assessed in terms of their consequences for social inequalities in health; (ii) new actions aimed at vulnerable groups or geographic areas will be assessed in terms of the target of reducing social inequalities in health; (iii) addressing social inequalities in health through health impact assessment and (iv) developing a plan of action to combat social inequalities in health (Fosse, 2008, p. 51).

*The Challenge of the Gradient* concerns itself with health inequalities right across the entire population (Norwegian Directorate of Health and Social Affairs, 2005) and the 2007 *National Strategy to Reduce Social Inequalities in Health* comes down squarely on the side of a structural analysis of health determinants (Ministry of Health and Care Services, 2007). It explicitly states the case that governments have a role to play in promoting health through public policy action. Four sets of public health objectives aim to *Reduce social inequalities in health by leveling up*. The four priority areas for achieving this are as follows:

- *Reduce social inequalities that contribute to inequalities in health.*
- *Reduce social inequalities in health behaviour and use of the health services.*
- *Targeted initiatives to promote social inclusion.*
- *Develop knowledge and cross-sectoral tools—to ensure that the measures we implement increasingly achieve their intended purposes.*

The report provides detailed schemes for achieving these sets of objectives. For example, in relation to income: 'As long as systematic inequalities in health are due to inequalities in the way society distributes resources, then it is the community's responsibility to take steps to make distribution fairer' (p. 33).

## Sweden

Health promotion activities in Sweden focus on strengthening democratic participation, promoting security and well-being of families, and reducing health inequalities. Sweden also provides an example of a governmental approach that strives to promote population health and reduce health inequalities by addressing the prerequisites of health.

The 2001 Swedish Ministry of Health and Social Affairs document *Towards Public Health on*

*Equal Terms* proposes an explicit role for health promotion policy in reducing health inequalities between various groups in society (Swedish Ministry of Health and Social Affairs, 2001). Policy areas identified include employment, education, agriculture, culture, transport and housing.

A 2003 report emphasized promoting health by closing the major health gaps in society and the 2002/2003 Public Health Objectives provided plans to achieve this (Swedish Ministry of Health and Social Affairs, 2003). Prerequisite-related areas were as follows: involvement in and influence on society; economic and social security; secure and healthy conditions for growing up; better health in working life; healthy, safe environments and products; health and medical care that more actively promotes good health; effective prevention of the spread of infections; and secure and safe sexuality and good reproductive health.

Municipalities and county councils were required to draw up and evaluate targets, and then report on these activities. The 2005 Public Health Policy Report provided a set of indicators for implementation of the public health policy at the national, regional and local levels during phase 1 (2003–2005) (Swedish National Institute for Public Health, 2005). As a result of extensive consultations, 42 priority proposals were presented. Twenty-nine deal with issues of how inequitable living conditions contribute to mental health, working life, air pollution and accidents, communicable diseases, overweight and physical inactivity, tobacco, alcohol, violence against women and inequalities in health. Thirteen proposals deal with policy and include increasing capacity for public health promotion involving more active engagement, coordinated regional public health promotion and support for more competence in public health matters among municipalities (Swedish National Institute for Public Health, 2005).

The social democratic nations are distinguished both by their explicit commitments and their longstanding commitments to implementing public policy that provides the prerequisites of health. They have also taken great efforts to make their policy documents and statements available in English-language versions.

## THE CONSERVATIVE WELFARE STATES

As noted, primary policy documents and statements related to these issues are generally not

available in English. The following is primarily drawn from the case studies in volumes that are available in English. Especially useful is work prepared for the European Portal on Health Inequalities and the Commission on the Social Determinants of Health (Mackenbach and Bakker, 2002; Commission on the Social Determinants of Health, 2008; Hogstedt *et al.*, 2008; DETERMINE, 2010a).

### Belgium

De Maeseener *et al.* prepared an overview of ‘intersectoral action for health in Belgium’ for a WHO/Health Canada publication related to the work of the Commission on Social Determinants of Health (De Maeseener *et al.*, 2007). They note that Belgium does not have a ‘global comprehensive policy framework’ to address the social determinants of health. They do note that this lack of a comprehensive health-related social determinants agenda does not dilute the Bismarkian-type insured health-care system that provides 100% health-care coverage.

More importantly, governmental action—in response to the increasing popularity of extreme right wing parties in the 1990s—has focused on improving housing and living conditions, and improving educational opportunities. These activities, however, were not carried out within a ‘health promotion’ framework.

Consistent with these activities, there now exists an Interministerial Conference for Social Integration which can take action on poverty, health and welfare policies. Maeseener *et al.* also describe a variety of local activities that apply intersectoral approaches to issues of poverty and children’s health, but these are not framed by an overall national policy. They conclude: ‘Although there is no formal policy addressing health inequalities, there are a lot of actions at different levels that contribute incrementally to health for the poor and the underserved’ (p. 11).

### France

Guillaumie (2007) provides an overview of the health promotion situation in France and concludes that it remains ‘hindered by a system still very centred on curative care and a lack of political consideration for health determinants’ (Guillaumie, 2007, p. 267). While there has been effort to establish a network through the National Institute for Health Promotion and

Education, lack of funding has not allowed for the established of 'professional excellence' in the health promotion field. *Guillaumie (2007)* commented that universities in Canada, '[R]ecognized as a world leader in health promotion', have influenced the development of health promotion in French through training and interaction with French students and academics. But results to date have been disappointing.'

An analysis by *Lang et al (Lang et al., 2003)* reaches similar conclusions concerning the health promotion scene in France. They argue that until the mid-1990s there was little if any policy interest in health in equalities related to socioeconomic issues. Conferences of health professionals and policy-makers raised these issues but they were not given priority in deliberations or reports.

But in a telling statement they point out that 'some aspects of the French health system have implicitly addressed the problem. The national health insurance and occupational medicine system are two examples of this' (p. 218). In the former case, France's health-care system provides universal care to any legal resident. In the latter case, France's occupational health system 'takes a global approach to health in the workplace, including interventions on working conditions' (p. 220). The authors conclude that numerous policies related to welfare payments, housing and occupational health may have worked to promote health. 'However, these were not designed with health in mind, and their effects on health inequalities have not been assessed' (p. 221).

## Germany

The German approach to explicit health promotion appears to be embedded within a behavioural approach. The DETERMINE case study points out that the Federal Ministry of Health created a set of initiatives that added disease and addiction prevention to the three existing pillars of therapy, rehabilitation and care (*DETERMINE, 2010b*). These initiatives, however, focused on:

- growing up healthy: nutrition, exercise, coping with stress;
- strengthening health competencies of patients;
- behaviour-related targets (e.g. reducing tobacco consumption);

- disease-related targets including depression, diabetes, breast cancer (screening programmes) and
- framing the establishment of disease management programmes. (<http://www.gesundheitsziele.de/>).

However, a recent report by the Federal Centre for Health Education and the Robert Koch Institute on the health of children and adolescents in Germany identified the importance of

- a comprehensive implementation of high-value concepts of health promotion in day-care centres and schools,
- family-support measures and
- development of quality in these resources.

However, like the other conservative welfare states, activities related to the prerequisites of health appear to be taken under auspices of other ministries than health. The Federal Ministry of Labour and Social Affairs:

[D]eals with three branches of social security: pensions, unemployment benefit and industrial accident insurance. The tasks include the maintenance of social systems, social integration and the framework for more jobs. Units within the purview of the ministry with responsibility for issues related to health inequalities are the following: with issues of social security (pensions, unemployment benefit and industrial accident insurance (*DETERMINE, 2010b*).

In Germany then—like the other conservative nations described—explicit health promotion concerned with the 'prerequisites of health' seems rather undeveloped, yet the conservative approach to promoting solidarity seems to indicate commitments to provision of the prerequisites of health in numerous areas.

## THE LATIN WELFARE STATES

Analyses of the health promotion scene related to provision of the prerequisites of health in these three Latin welfare states is fairly straightforward: there is little explicit attention paid to reducing health inequalities through provision of the prerequisites of health: 'In most Latin countries, social inequalities in health have received little attention in research, and even less in public health policy' (*Costa et al., 2008, p. 161*). As is the case for the conservative welfare states, this does not necessarily mean

that there is no public policy activity related to these issues, but it does provide evidence that there has been little explicit penetration of health promotion concepts related to the prerequisites of health into the making of public policy.

### Greece

There is little explicit concern with health inequalities and the prerequisites of health in Greece government policy documents (Tountas *et al.*, 2003). Nevertheless, there is government activity in many prerequisites of health-related areas but these are not explicitly identified as being concerned with promoting health.

These areas are concerned with poverty reduction, improving housing quality, reducing unemployment and improving access to health care. The authors comment: 'Although these policies have a considerable effect in alleviating health inequalities, they have not been planned as such, as in Greece socio-economic inequalities in health have not been recognized as a priority in public policy (p. 227)'. The DETERMINE Greece case study concludes:

Recent policy and legislative articles on social justice/ social inclusion to tackle macro environmental factors include general references to health inequalities. The current Public Health Policy (officially implemented by the Greek Ministry of Health, Welfare and Social Solidarity) does express the aim of integrating specific vulnerable groups of the population, but lacks specific objectives, quantitative targets and timeframes (DETERMINE, 2010c).

Ballas and Tsoukas (Ballas and Tsoukas, 2004) place this reluctance to specify and measure objectives as endemic to the entire Greek health-care system, but in terms of the present analysis, the lack of specific concern with reducing health inequalities is of primary importance.

### Italy

Until the mid-1990s health policy was focused solely on health care (Costa *et al.*, 2008). The 1998–2000 National Health Plan had as one of its many objectives reducing social inequalities in health, but these objectives—according to the authors—were not put into practice nor were any objectives or targets identified. A 2003–2005 plan did target those living in poverty,

persons with mental illness and specific immigrant groups, however, for policy action.

But the lack of any central organization to address broader issues is apparent: 'There is no institution or agency explicitly committed to linking health goals to non-health policies' (p. 185). Not surprisingly, the issue of health determinants is not seen as being high on the public agenda nor has it aroused much interest among the Italian public. But again, this does not suggest that there has not been public policy activity that is concerned with the prerequisites of health.

The social assistance program involved a variety of schemes yet are seen as being undeveloped as compared with other nations relying much on volunteer agencies. Pension plans have been revised and updated, workplace improvements have been legislated, and educational opportunities enlarged. But such activities are consistent with an observation made by Costa *et al.*'s in an earlier publication: 'Some general policies, such as those on employment or income support, or specific ones such as those on housing, education and the environment, may be beneficial but are not designed to have an impact on health' (Costa *et al.*, 2003, p. 236).

### Spain

Spain provides a similar portrait as that seen in Greece and Italy. Health policy is decided upon by the National Ministry of Health and the departments of what are called the Autonomous Communities (Ramos-Diaz and Castedo, 2008). These plans do not contain any references to issues of inequalities in health and only one region mentions socioeconomic inequalities.

Ramos-Diaz and Castedo (2008) argue that Spain's health and social welfare systems are underdeveloped in relation to other European nations. Much of this has to do with the late arrival of democracy in Spain, a result of the long-standing Franco dictatorship. In 1996, however, a report by Navarro, Benach and others outlined the extent of health inequalities and their socioeconomic roots. This came to be known as the 'Spanish Black Report'. But the newly elected conservative government in 1997 ignored its findings and its recommendations were rejected. Ramos-Diaz and Castedo (2008) argue that these issues continue to be absent from political discourse and do not appear to be at all on the Spanish political agenda.

Despite this lack of explicit attention to issues of health inequalities and their sources, there is still policy attention to prerequisite-related issues: 'When policies are designed with the intention of affecting key social dimensions such as the labour market or social protection, these are not understood as social determinants of health' (Ramos-Diaz and Castedo, 2008, p. 285).

## SUMMARY

This analysis indicates that it is the liberal and social democratic welfare states that provide explicit recognition of the importance of providing the prerequisites of health through public policy activities, the conservative and Latin welfare states, less so. It is rather striking how the authors responsible for the national case studies of these conservative and Latin welfare states note that numerous initiatives that appear to address the prerequisites of health do not place these activities within a health promotion or reducing health inequalities framework.

These findings suggest that health promoters in these conservative and Latin welfare states may find it more difficult to engage in activities that advocate for public policy activities to provide the prerequisites of health as this is not seen by governing authorities as a health promotion activity. The extent to which the presence or absence of these commitments to provision of the prerequisites of health convert into providing public policy that actually does provide these prerequisites and the implications for health promoters concerned with these issues is taken up in Part 2 of this article.

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