

**THE PARAMETERS OF CHILDREN'S HEALTH:
KEY CONCEPTS FROM THE POLITICAL ECONOMY OF HEALTH LITERATURE**

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Abstract: In this article key aspects of a political economy approach to addressing children's health are identified. These aspects include a concern with how power and influence of various societal sectors come to shape the social determinants of children's health through the creation of specific forms of public policy. These public policies affect children's health through two primary pathways: shaping the social determinants of parents' health and shaping specific social determinants of children's health. These approaches cluster such that a worlds of welfare states approach can illuminate specific aspects of Canada's approach to creating public policies that shape children's health. Implications for promoting children's health that derive from a political economy approach are presented.

Keywords: social determinants of health, children's health, political economy, public policy

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Political economy models of society are concerned with how political ideology and power and influence operate through economic and political systems to create public policy that distributes material and social resources (Bryant, 2009). Central to this perspective is the idea that politics and economics are intrinsically related and this dynamic shapes public policy development. As applied to understanding health and the determinants of health, a political economy approach draws a direct link between these societal structures and processes, the making of public policy that shapes the social determinants of health, and the health of the overall population and specific groups classified according to social class, gender, age, and race among other characteristics (Coburn, 2010).

There are a variety of political economy models and in this paper I consider the insights that a critical materialist approach offers (Coburn, 2010). Such an approach sees public policies that shape health policies as resulting from the organization of society which is itself shaped by the relative balance of power and influence among competing societal sectors. As a result, improving health involves acting upon these societal dynamics (Raphael, 2014a). Children's health is directly influenced by the public policies that result from these structures and processes in two ways. The first pathway is through public policy that shapes the living and working conditions of their parents. The second pathway is through public policies that directly affect children and their development. Since jurisdictions differ in how their economic and political systems operate, it is not surprising there are differences in the overall health of children from different jurisdictions (Innocenti Research Centre, 2013).

Figure 1 provides a model of the structures and processes that shape children's health identified by a critical materialist political economy approach. In the following sections, I describe each of the model's components and their importance for children's health. For ease of presentation, I begin with the most concrete aspects of the model, children's health, and then work my way up to the more abstract concepts of the political economy approach. The purpose is to provide means of making sense of the material contained in this special issue on the political economy of children's health.

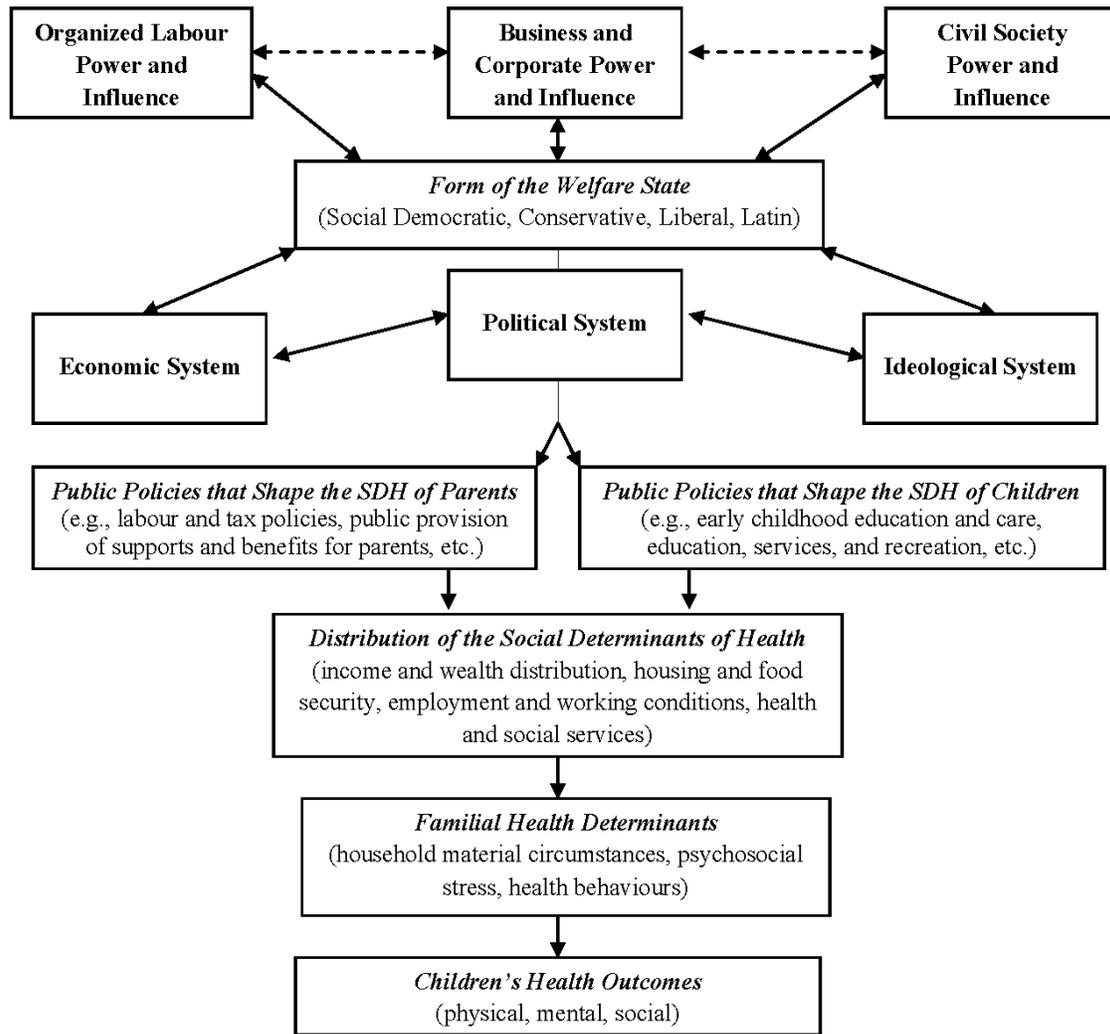


Figure 1: Depiction of Pathways by which the Key Concepts of a Political Economy Approach Explain Children’s Health Outcomes both within and across Jurisdictions

Children’s Health

Children’s health is usually considered in terms of physical, mental, and social well-being. Physical health includes measures of mortality such as infant mortality and mortality prior to age 18, and measures of morbidity such as the presence of various diseases or the occurrence of injury. It can also include functional health or health-related behaviours such as diet or physical activity. Mental health includes measures of childhood psychological functioning and coping mechanisms as well as the presence of disorders. Social health includes measures of school performance and academic achievement, quality of peer relationships, as well as delinquency.

Another set of indicators concerns the extent of inequalities among children in a jurisdiction on these and similar measures.

The Innocenti Research Centre provides indicators of health and well-being for wealthy developed nations that include many of these and additional indicators that capture the broad dimensions of children’s health and well-being. Table 1 provides some of these that were provided in a recent report (Innocenti Research Centre, 2013). Analyses are also available for extent of injuries (Innocenti Research Centre, 2001a), teenage births (Innocenti Research Centre, 2001b), mortality by abuse and neglect (Innocenti Research Centre, 2003) and extent of inequalities among children in health and well-being (Innocenti Research Centre, 2010).

Dimensions	Components	Indicators
Dimension 1: Material well-being	Monetary deprivation	Relative child poverty rate
		Relative child poverty gap
	Material deprivation	Child deprivation rate
		Low family affluence rate
Dimension 2: Health and safety	Health at birth	Infant mortality rate
		Low birthweight rate
	Preventive health services	Overall immunization rate
Dimension 3: Education	Participation	Participation rate: early childhood education
		Participation rate: further education, age 15 to 19
		NEET rate (% age 15 to 19 not in education, employment or training)
	Achievement	Average PISA scores in reading, maths and science
Dimension 4: Behaviours and risks	Health behaviours	Being overweight
		Eating breakfast
		Eating fruit
		Taking exercise
	Risk behaviours	Teenage fertility rate
		Smoking
		Alcohol
		Cannabis
Exposure to violence	Fighting Being bullied	

Dimension 5: Housing and environment	Housing	Rooms per person Multiple housing problems
	Environmental safety	Homicide rate Air pollution

Source: Innocenti Research Centre. (2013). *Child well-being in rich countries: A comparative overview*, Box 1, p. 5. Florence: Innocenti Research Centre.

The Centre’s 2013 Report Card examined children’s well-being along five dimensions (Innocenti Research Centre, 2013). Canada’s overall rank was 17th of 29 wealthy developed nations. It ranks 15th in material well-being, 27th in health and safety, 14th in education, 16th in behaviours and risks, and 11th in housing and environment. Numerous analyses show these health and wellness rankings to be strongly determined by children and their families’ living and working conditions. These factors have come to be called the social determinants of health (Mikkonen & Raphael, 2010). The next section explores how these social determinants manifest within the family context.

Familial Health Determinants

Families’ living and working conditions differ within and across jurisdictions. Overall conditions are more favourable in some nations than others (e.g., poverty rates) and variation is greater in some nations than others (e.g., extent of income inequality) (Innocenti Research Centre, 2012). Both sets of measures are related to children’s health outcomes. The most obvious manifestations of these differences – important because they predict children’s health outcomes – are familial material circumstances, psychosocial factors including stress experienced by families and coping mechanisms, and health-related behaviours (Benzeval, Judge, & Whitehead, 1995). Material circumstances refer to the concrete exposures to health strengthening and health threatening conditions that are associated with income and wealth. Income and wealth are important as these provide access to a wide range of material goods such as housing, food, and learning and recreational opportunities, among others. In addition, since income and wealth are associated with spatial segregation, differences manifest in quality of neighbourhoods and the opportunities for education and recreation associated with these neighbourhoods. The amount of crime and threat are also associated with material circumstances (Raphael, 2011).

These material exposures can have both immediate and long-lasting effects upon children’s health. The latter have been termed *latency* effects and can result from biological processes during pregnancy and early childhood associated with poor maternal diet and experience of stress (Hertzman & Frank, 2006). Early childhood experiences, such as the experience of numerous infections or exposures to adverse housing conditions, also appear to have immediate and later health effects regardless of later life circumstances. As one example, adverse childhood living circumstances are excellent predictors of cardiovascular disease and adult-onset diabetes during later adulthood (Raphael et al., 2003; Raphael & Farrell, 2002).

In response to these material circumstances, families experience differences in a number of psychosocial variables such as stress, sense of efficacy and control, and self-identity. These

come to shape parents' and children's health in both the present and future (Lynch, Kaplan, & Salonen, 1997). Psychological health-related effects may also result from early experience. A general non-adaptive reaction to stress may be established during early childhood as well as a general sense of hopelessness and lack of control, both of which are important determinants of health (Irwin, Siddiqui, & Hertzman, 2007).

The third familial determinant of health is how experience of varying circumstances and the levels of stress associated with these circumstances lead to the adoption of health-supporting or health-threatening behaviours. In the latter case, these behaviours can be seen as coping responses to adverse life circumstances. Numerous Canadian studies show that children raised in familial conditions of low income, unemployment or precarious employment, poor quality housing, and food insecurity are more likely to take up risk-related behaviours such as smoking, excessive alcohol consumption, and lack of physical activity (Health Canada, 1999). Similarly, adoption of carbohydrate-dense diets and weight gain are also seen as means of coping with difficult circumstances (Wilkinson, 1996). The troika of material circumstances, psychosocial processes, and behavioural responses are shaped by what are called the social determinants of health.

Social Determinants of Health

Social determinants of health are the specific economic and social conditions that shape the health of individuals, communities, and jurisdictions as a whole (Mikkonen & Raphael, 2010). Canadian researchers have outlined 14 of these: Aboriginal status, disability status, early life, education, employment and working conditions, food security, gender, health services, housing, income and income distribution, race, social exclusion, social safety net, and unemployment and employment insecurity (Raphael, 2009). Social determinants such as Aboriginal status, disability status, gender, and race can be thought of as social locations that do not, by themselves, lead to differing health outcomes, but interact with societal conditions to create particular health outcomes.

An emphasis upon societal conditions as determinants of health contrasts with the traditional health sciences and public health focus upon biomedical and behavioural risk factors. Since a social determinants of health approach sees the mainsprings of health as being how a society organizes and distributes economic and social resources, it directs attention to economic and social policies as means of improving it. It also requires consideration of the political, economic, and social forces that shape their distribution amongst the population.

Distribution of the Social Determinants of Health

Much social determinants of health research simply focuses on determining the relationship between a social determinant of health and health status, so a researcher may document, for example, that lower income is associated with adverse health outcomes among parents and their children. Or a researcher may demonstrate that food insecurity is related to poor health status among parents and children, as is living in crowded housing, and so on. This approach says little about how these poor-quality social determinants of health come about (Raphael & Bryant, 2002).

Social determinants of health do not exist in a vacuum. Their quality and availability to the population are usually a result of public policy decisions made by governing authorities (Graham, 2004). As one example, consider the social determinant of health of early life. Early life is shaped by availability of sufficient material resources that assure adequate educational opportunities, food, and housing among others (Raphael, 2014b). Much of this has to do with the employment security of parents and the quality of their working conditions and wages. The availability of quality, regulated child care is an especially important policy option in support of early life (Esping-Andersen, 2002). These are not issues that usually come under individual control. A policy-oriented approach places such findings within a broader policy context. The next section considers the public policies that shape the quality and distribution of the social determinants of children's health.

Public Policy

The term *social policy* is usually used to refer to issues that have direct relevance to social welfare, such as social assistance, child and family policy, and housing policy, but the factors that shape the health of children are affected by a wide range of other public policies that include labour and employment, revenue, and tax policies, among others. These public policy activities are courses of action or inaction taken by public authorities – usually governments – to address a given problem or set of problems (Briggs, 1961). Governments constantly make decisions about a wide range of issues, such as national defence and the organization and delivery of health, social, and other services. The decisions that are the special concern here determine how economic and social resources are distributed among the population.

Governments influence this distribution by establishing taxation levels, the nature and quality of benefits – whether these benefits are universal or targeted – and how employment agreements are negotiated. Governments are also responsible for establishing housing policies, maintaining transportation systems, enacting labour regulations and laws, and providing training related to employment and education.

Table 2 shows the interconnections between public policy issues and the social determinants of health in general and children's health in particular. These public policy decisions that provide equitable or inequitable distribution of the social determinants of health do not exist in a vacuum. They reflect the operation of three primary societal systems: the economic, political, and ideological.

Table 2
Social Determinants of Children's Health and their Public Policy Antecedents

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

Economic, Political, and Ideological Systems

Economic system

The economic system both creates and distributes economic resources amongst the population. Since all economic systems in wealthy developed nations are capitalist, market principles – of which profit-making is paramount – have the potential to drive their operations (Coburn, 2010). Some of the main features associated with the market process that impact the health of children are wage structures their parents experience, benefits available through work, working conditions, and vacation time of their parents, among others (Jackson, 2009).

It has long been recognized, however, that without State intervention in the operation of the market economy, the distribution of economic resources becomes skewed in favour of the wealthy and powerful (Macarov, 2003). In addition, some structures and processes necessary for societal functioning may not be made available at all by the economic system. The welfare state arose because the economic system itself is not capable of dealing with provision of basic societal resources such as education, health care, housing, and other programs and services that provide citizens with resources necessary for well-being (Teeple, 2000).

What are some of the influences upon how the market economy operates and distributes economic resources amongst the population? Political economists speak of the power and influence of societal groups such as the business and corporate sectors, the organized labour sector, and civil society (Coburn, 2010). These sectors influence the political system that can manage the economic system through public policy-making (see below). The business and corporate sector has power and influence over the economic and political systems through its control of many economic levers such as its ability to move and invest capital (Brooks & Miljan, 2003).

The organized labour sector usually supports greater redistribution of economic resources through higher taxation on the business and corporate sector, stronger government management of aspects of the workplace such as wages and benefits, and greater provision of supports and benefits through government programs funded by taxes (Navarro et al., 2004). The civil society sector gains power and influence to influence the economic system from its ability to influence public opinion and shape public policy through networks of agencies, organizations, and other non-governmental institutions (Brady, 2009).

Political system

The political system consists of the organization of the State and its collection of laws and regulations. The political structure can intervene in the operation of the economic system by enacting laws and regulations that affect employment practices and by having governments provide supports and services to the citizenry through programs and benefits. These supports, benefits, and services come from the enactment of corporate and personal taxes, which are usually progressive in that greater proportions of taxes accrue from those with higher incomes.

There are many specific areas where State activity impacts upon the social determinants of the health of children. Working through the making of public policy, these areas include income and income distribution, employment and job insecurity, working conditions, housing and food security, and the availability of health and social services, among others (Mikkonen & Raphael, 2010). These social determinants of health indirectly affect the living conditions – and health – of children by shaping the living conditions of their parents; in other cases the effect is more direct. One example of a direct effect would be in the provision of differing forms of child care to families (Friendly & Prentice, 2009). Child care can be provided as a universal right or as a commodity that must be purchased. Another instance would be whether college and university education is provided to all or must be bought.

Ideological system

Finally, the means by which economic and political systems distribute resources are usually justified by dominant discourses on the nature of society and the different roles that the State, Economic Marketplace, and Family should play in providing economic and social security. These different discourses usually involve dichotomies such as socialism versus liberalism, social justice versus economic justice, and communal versus individual responsibility for well-being.

The socialism versus liberalism dichotomy is well described by Wiktorowicz (2010). She points out that liberalism emphasizes personal freedom whereby individuals can pursue their own interests free of coercion by government. Governments should intervene only to assure the free market distributes basic resources. In contrast, socialism distrusts the results provided by the market economy and emphasizes that assets should be collectively owned with the benefits of the economic system distributed equitably across the population. In essence, liberalism is concerned with equality of opportunity, while socialism is concerned with equality of result. Anglo-Saxon nations tend towards liberalism, European nations towards socialism.

The social justice versus economic justice dichotomy is concerned with whether there is an inherent right for everyone to receive the benefits available in a society or whether individuals are entitled to only those earned through their participation in the market economy (Hofrichter, 2003). Not surprisingly, this dichotomy is related to the liberalism versus socialism dichotomy. The business sector usually espouses the economic justice view while the labour sector and frequently the civil society sector favour the social justice view. Again, Anglo-Saxon nations tend towards the economic justice approach while European nations lean towards the social justice view.

Related to both of these dichotomies is the issue of broad concepts of society and how these lead to action and change in a society. Stone (2002) contrasts individualized (market) versus communal (polis) approaches. In the market conception of society, the emphasis is on the individual and the primary motivation for action is self-interest. Society is inherently competitive and the source of change is the exchange of material goods through the market economy.

By contrast, in the polis view of society the focus is on the community and there is a strong role for public interest in addition to self-interest. While there is competition among

individuals there is also cooperation in the pursuit of common goals. The building blocks of social action are groups and organizations. The building blocks of change are ideas and alliances rather than material exchanges among individuals. Finally the polis model sees the pursuit of the public interest as a source of change.

More recently, analysis had been made of the impact of neo-liberalism as a societal doctrine that shapes the distribution of resources. Neo-liberalism is an ideology that believes that governments should withdraw from managing the economy thereby ceding more power and influence to the business and corporate sector (Coburn, 2010). This has been seen as leading to the skewing of the distribution of the social determinants of health and threatening the health of citizens in general and children in particular.

The ideological system is especially important because it shapes the means by which the population comes to understand these issues. If the general public is convinced of the validity of neo-liberal arguments about the primacy of the marketplace over the State, then little can be expected to come from public policies that will manage the economy in the service of children's health. Ideological beliefs of the public are important determinants of whether a jurisdiction comes to address the social determinants of health through public policy action. These ways of thinking about society and the responsibilities for providing citizens with economic and social security come together with the operation of the political and economic systems to shape what has been called the differing worlds of welfare states.

Form of the Welfare State

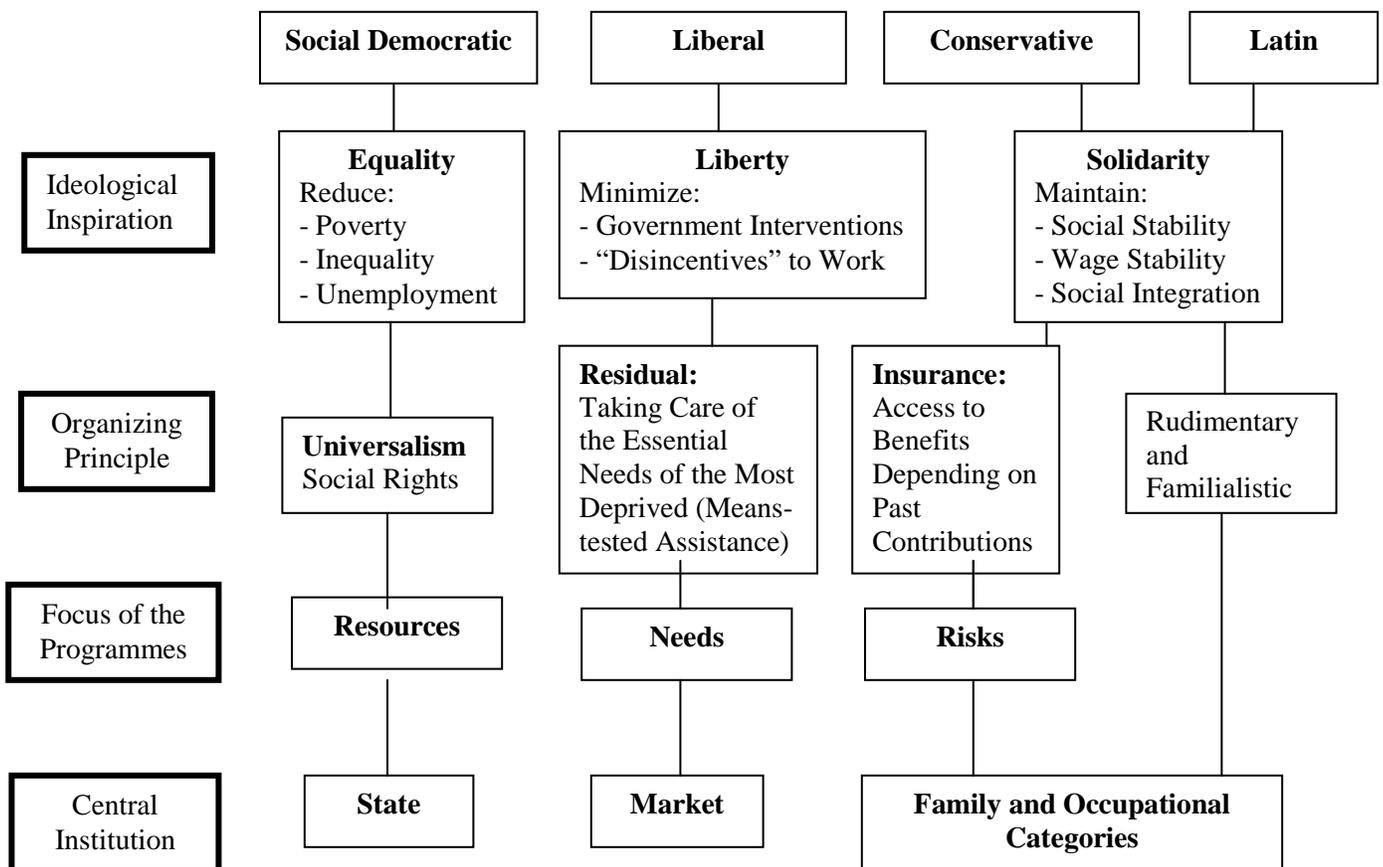
These three aspects – the economic, political, and ideological – come together to create distinctive forms of governance that have come to be called the worlds of welfare approach. In *The Three Worlds of Welfare Capitalism*, Esping-Andersen (1990) identified three welfare state regimes: the Social Democratic, Conservative, and Liberal. As a political economy model, it conceives ideas and institutions – and the public policy that flows from these – as evolving from societal arrangements influenced by historical traditions. The central features of welfare regimes are their extent of social stratification, decommmodification, and the relative role of the State, Market, and Family in providing economic and social security to the population. Importantly, the State's role is influenced by class mobilization, in that the loyalties of the working and middle classes determine the forms by which these systems operate. These differing patterns of loyalties have contributed to the formation and maintenance of these welfare state regimes.

The Social Democratic welfare state (e.g., Denmark, Finland, Norway, and Sweden) has been strongly influenced by social democratic ideology and politics. Its concern with Equality outlines a key role for the State in addressing inequality and providing the population with various forms of economic and social security (Saint-Arnaud & Bernard, 2003). Its provision of programs and supports on a universal basis is consistent with its goal of reducing social stratification and decommodifying the necessities of life. In essence, the Social Democratic welfare state strives to provide the means by which one can live a decent life independent of employment market involvement.

The Conservative welfare state (e.g., Belgium, France, Germany, and the Netherlands) is distinguished by its concern with maintaining Stability (Saint-Arnaud & Bernard, 2003). Historically, governance is by Christian Democratic parties that maintain many aspects of social stratification, a moderate degree of decommodification of societal resources, and an important role for the Family in providing economic and social support. The Church played a significant role in its development. An underdeveloped form of the Conservative welfare state – the Latin (e.g., Greece, Italy, Portugal, and Spain) – has been added to Esping-Anderson’s three regimes by Saint-Arnaud and Bernard (2003).

Finally, the emphasis of the Liberal welfare state (e.g., Australia, Canada, the United Kingdom, and the United States) is on Liberty and is dominated by the Market and ruled by generally pro-business political parties (Saint-Arnaud & Bernard, 2003). Little attempt is made to reduce social stratification and its degree of decommodification is the lowest. There is little State intervention in the operation of the economic system.

Figure 2. Ideological Variations in Forms of the Welfare State



Source: Saint-Arnaud, S., & Bernard, P. (2003). Convergence or resilience? A hierarchical cluster analysis of the welfare regimes in advanced countries. *Current Sociology*, 51(5), 499–527, Figure 2, p. 503.

Esping-Andersen's distinction between Social Democratic, Conservative, including Latin, and Liberal welfare states has much to do with the making of public policy that addresses the social determinants of health. Figure 2 shows the basic elements and characteristics of these differing forms of welfare states and their alignment with social determinants of health-related public policy is apparent (Raphael, 2013a, 2013b). These differing forms of the welfare state have not come about by accident but are shaped and maintained by ideologies of governing authorities informed by the politics of political parties.

This approach is important as it considers how the ideological views of governments shape receptivity to the timing and content of public policies. This model suggests that addressing the social determinants of children's health through public policy action in Liberal welfare states such as Canada will require no less than shifting the role of the State. This shift will occur as a result of addressing imbalances in power and influence that at present favour the business and corporate sector. Public health activities designed to address the social determinants of health may help facilitate such a shift (Brassolotto, Raphael, & Baldeo, 2014).

Power and Influence of Societal Sectors

At the top of Figure 1 are the three key sectors that influence the entire public policy process. The *Business and Corporate Sector* is centrally placed as it has the greatest potential in capitalist societies – and all wealthy developed nations are capitalist – to shape aspects of economic and political systems, public policy-making, and the quality and distribution of the social determinants of health. It also has the ability to shape the attitudes and values of the public through its creation of ideological discourse – the ways society members come to think about these issues (Grabb, 2007). The business sector usually favours less provision of social and economic security and advocates for weakened government management of employment practices, coupled with fewer support programs and benefits, all of which results in less redistribution of income and wealth (Langille, 2009; Leys, 2001; Macarov, 2003). Its call for lower taxes – especially for the corporate sector and the wealthy – weakens governmental ability to provide benefits and supports that provide economic and social security to the population (Menahem, 2010).

The organized labour sector usually supports greater redistribution through higher taxation on the business and corporate sector and the wealthy, stronger government management of the workplace, and greater provision of supports and benefits (Navarro et al., 2004). It gains power and influence through the percentage of the population that belong to trade unions and its alliance with governing parties of the left (Brady, 2009; Bryant, 2009; Navarro & Shi, 2001). The civil society sector gains power and influence from its ability to influence public opinion and shape public policy through networks of agencies, organizations, and other non-governmental institutions (Brady, 2009). And, of course, the citizenry itself has influence through its ability to elect representatives to governments.

The balance of power among sectors differs among nations with resulting impacts on the distribution of the social determinants of health (Raphael, 2013b). It has long been noted that public policy approaches of the social democratic nations of Denmark, Finland, Norway, and Sweden act such that the distribution of the social determinants of health is more equitable than

in the Liberal nations of Australia, Canada, New Zealand, the U.K., and the U.S.A. (Health Council of Canada, 2010; Innocenti Research Centre, 2005; Navarro & Shi, 2002). Denmark provides a conundrum for a welfare state analysis in that its life expectancy is very low in comparison to other wealthy developed nations. Its infant mortality rate, however, is very favourable and there is evidence that it has begun to explicitly address issues of health equity in its public policy (Povlsen, Karlsson, Regber, Sandstig, & Fosse, 2014).

The Conservative nations such as Belgium, France, Germany, and the Netherlands fall midway between the Social Democratic and Liberal nations, with the Latin states closer to the Liberal states. In both the Social Democratic and Conservative nations, consultation and communication among these sectors is common, sometimes institutionalized and sometimes informal (Swank, 2002). This is usually not the case in the Liberal nations, a situation that is sometimes called “disorganized capitalism” (Offe, 1985).

Implications

Attempts to improve children’s health can benefit from the insights provided by a political economy approach. The approach specifies that children’s health is shaped by a range of societal structures and processes that act to distribute the social determinants of both children’s and their parents’ health. These structures and processes create specific forms of public policy that provide parents and their children with the economic and social conditions necessary for health. These public policy areas include income and wealth distribution, employment security and working conditions, features supporting early child development, food and housing security, and the provision of health and social services.

Each jurisdiction will see a differing balance of power and influence among the business, labour, and civil society sectors. These differences in power and influence have a profound influence upon the direction that public policy will take. Ultimately, these differences in power – and the resultant distribution of the social determinants of children’s health – are shaped by the politics of a nation. As well intentioned as efforts will be to work directly to influence public policy and strengthen specific social determinants of children’s health through community action and direct service delivery, these efforts may have limited effects.

Instead, the political economy approach argues that the key goal should be to shape the politics of a nation in the direction of supporting children’s health. This will require controlling the influence of the business sector and strengthening the organized labour and civil society sectors. It will also involve support of, and election of, political parties whose positions are consistent with such an approach. Ultimately, the promotion of children’s health requires engagement in the political process with the goal of reordering a society’s economic and political systems such that they provide the conditions necessary for children’s health.

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