LET'S TALK:
REDISTRIBUTING POWER TO ADVANCE HEALTH EQUITY

SUPPLEMENT 1 – THE EVIDENCE BASE FOR FOCUSING ON POWER IMBALANCE AS A ROOT CAUSE OF HEALTH INEQUITIES

TABLE OF CONTENTS

This document is one of three supplements that delve deeper into the concepts introduced in *Let's Talk: Redistributing power to advance health equity.*[1] *Supplement 2 – Public health roles in addressing power imbalances in the Canadian context: Summary of interviews and considerations*[3] *and Supplement 3 – Additional frameworks for conceptualizing and analyzing power*[4] are also available for your review.

INTRODUCTION

In this supplementary document to *Let's Talk: Redistributing power to advance health equity*,[1] we review and summarize the evidence linking power to health outcomes.

A useful starting point for this evidence review is a recent summary by Popay et al.[2] of the causal theory connecting building power to greater health equity:

> Community-based initiatives espousing empowerment are prominent in the health field. Syme termed the theory underpinning these "control over one's destiny." Different causal pathways from control to health outcomes are proposed. Living in disadvantaged neighbourhoods can produce a sense of collective threat and powerlessness: chronic stressors causing distress manifested as anxiety, anger or depression, which damages health. Obversely, empowerment processes could reduce the negative health impact of disadvantage if, for example, a community prevents the siting of a toxic waste facility locally or attracts resources for environmental improvements. Additionally, a community's experiential knowledge can help develop more acceptable, and therefore more effective, ways to address the risks to health they face. Positive health effects can also arise indirectly, if participation in collective activities increases social cohesion or leads to an improved sense of self-efficacy and control in individuals. Finally, engagement in community action to address inequalities can increase "critical health literacy" contributing to democratic renewal (e.g. increased voting rates), greater political engagement and pressure for more socially just policies.[pp1254–5]

This review of evidence was developed through iterative searches of PubMed. The word *power* has several different meanings in the public health literature, not all of which are relevant to this evidence review (e.g., statistical power), and a number of words and phrases are being used as synonyms to the concept of power in the public health literature (e.g., "control over one's destiny"). As a result, and due to limited resources, this review is not comprehensive. In general, we reviewed peer-reviewed articles, as well as the grey literature and books, all found using search terms such as "power," "empowerment" and "community power" in combination with "health or disease," and a list of countries (e.g., Canada, France, Germany, Italy, Japan, England, United Kingdom, United States, Sweden, Norway, Finland). When mining articles, we added in relevant articles and reports that were cited. We generally excluded articles about the medical setting, for example, about the power of patients or nurses in the health care system. We also excluded studies of individual empowerment in developing countries as they were less relevant to power in Canada.

***A note on terminology:* empowerment *versus* building power**

In this supplement and in the associated *Let's Talk*,[1] we choose to use "building power" and "community power building" rather than "empowerment" and "community empowerment" for two reasons.

First, as Woodall et al.[5] and Christens[6] pointed out, the term empowerment has become diluted over the years, and many people now use it to refer to individualistic empowerment. As Christens stated, "the prevalence of individualistic notions of empowerment are related to the ascendant neoliberal ideology and are responsible for much of empowerment's terminological dilution."[6(p373)] And, importantly, Woodall et al. identified that "individual empowerment alone has a limited impact on addressing health inequalities and may be illusory in that it does not lead to an increase in actual power or resources."[5(p743)] Furthermore, individualistic conceptualizations of empowerment, according to Christens, fail to include "psychological empowerment, which has been conceptualized ecologically as a multilevel construct that is inextricable from organizational and community-level empowerment."[6(p373)] We believe that building power and community power building incorporate these broader, non-individualistic conceptualizations.

Second, recent critiques of the term empowerment focus on the idea that everyone has innate power and that power is not something one person or group gives to another person or group, as the term empowerment implies. Using instead "building power with" and "building community power with" avoids implying that power can be bestowed by or to someone.

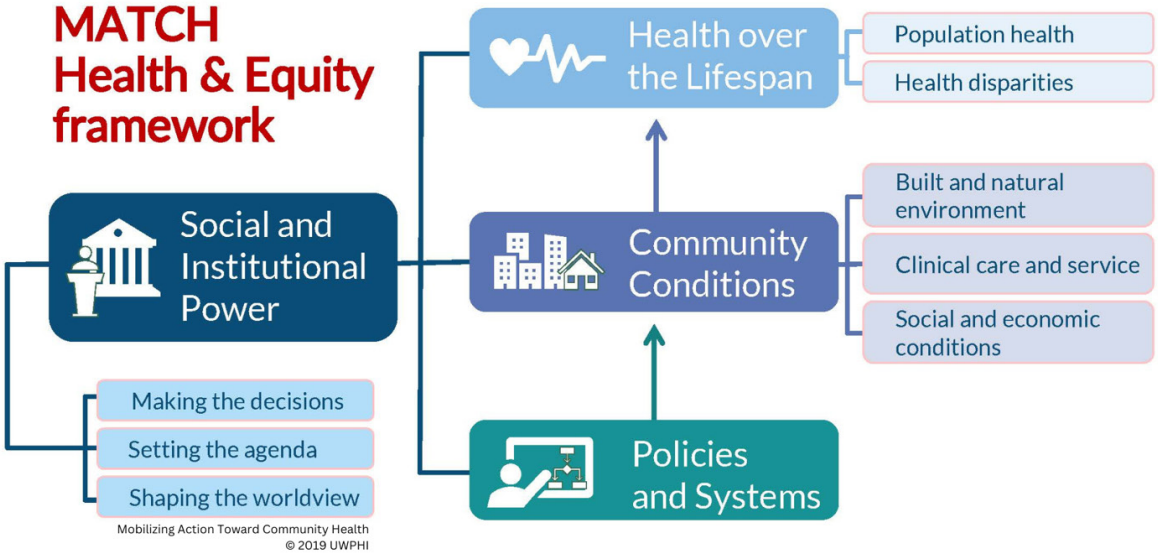
In cases where we quote from others and where we are referring to a historical use of the term, we make exceptions and use the term empowerment.

THEORETICAL FRAMEWORKS LINKING HEALTH OUTCOMES TO THE CONCEPT OF POWER

We begin this evidence review by describing some of the theory that links power to health outcomes.

The University of Wisconsin Population Health Institute's Mobilizing Action Toward Community Health (MATCH) program developed the logic model in Figure 1, linking social and institutional power to health outcomes through three intermediary pathways: health over the lifespan, community conditions, and policies and systems.[7] The model identifies three forms of social and institutional power (derived from the three faces of power framework described in *Let's Talk: Redistributing power for health equity*[1]). Those forms of power influence health outcomes directly (health over the lifespan) as measured by population health outcomes and health disparities; community conditions including the built and natural environment, clinical care and services, and social and economic conditions; and policies and systems.

Figure 1: MATCH health & equity framework model[7(p12)]



Whitehead et al.[8] recently synthesized logic models linking "control over destiny" — a concept that public health has used to reflect aspects of power — to socioeconomic inequalities in health. They identified theories at three interrelated levels:

- Micro/personal: "A person's social position influences the resources they have to control their destiny (in terms of money, power, information, prestige) and influence critical decisions affecting their lives."[(p54)]
- Meso/community: "Notions of community/collective control go beyond individual circumstances to encompass the strength/power generated by joining together to have greater influence over material and social conditions in immediate neighbourhoods/living space."[(p54)]
- Macro/societal: "Cultural orientation towards different groups in the population (for example son preference and gender bias) and sociopolitical transitions (for example, experiences of former USSR countries) operate at the level of whole societies, influencing the degree of control that members of a society have over their lives."[(p54)]

At the micro/personal level, they summarized theories in the logic model in Figure 2, showing how low social position and control (actual and perceived) can lead to increased prevalence of physical and mental health problems.

Figure 2: Theoretical pathways at the micro/personal level linking low control and socioeconomic inequalities in health[8(p54)]

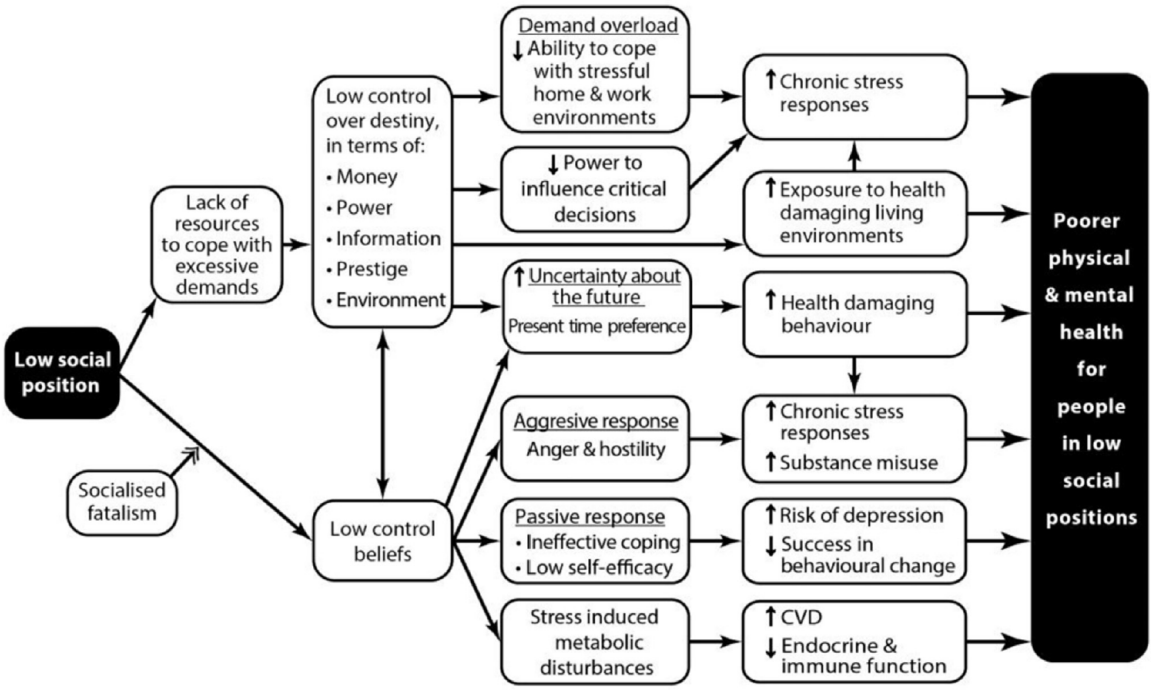
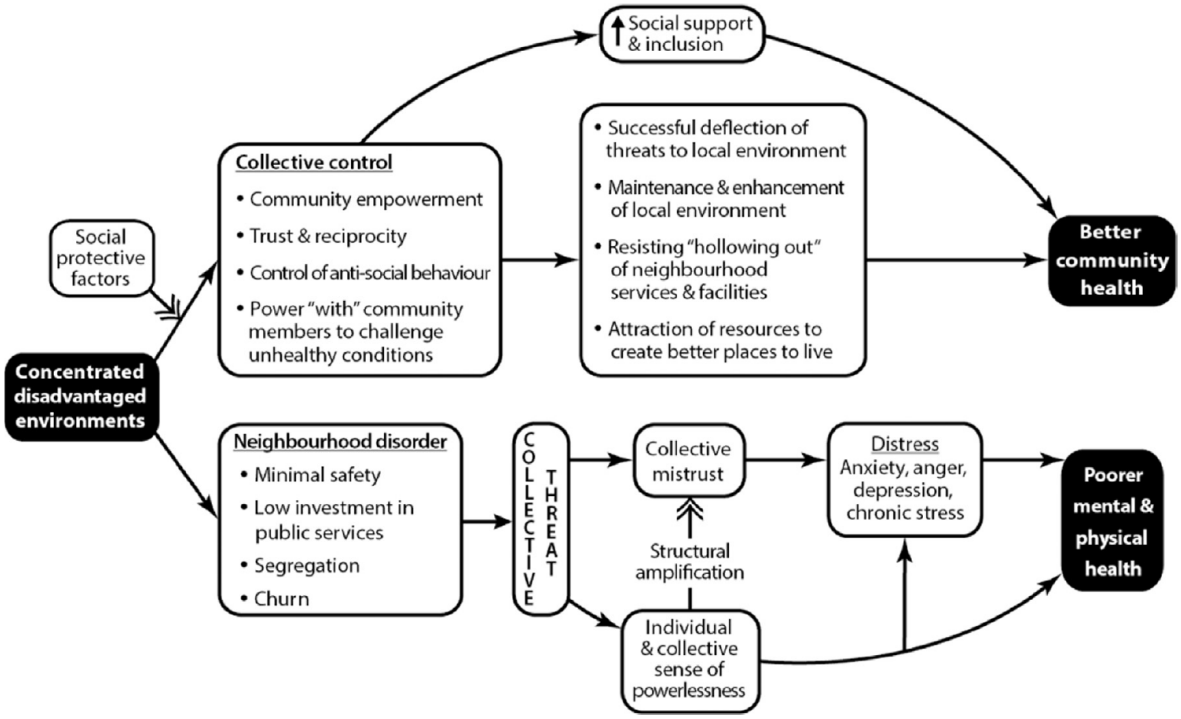


Figure 3 contains their logic model summarizing theories at the meso/community level that focus on the interaction of people with the places in which they live. Theories are grouped into two pathways: processes that lead to and impacts of neighbourhood disorder, and collective control that considers social protective factors in communities that affect their capacity to challenge disadvantaged conditions.

Figure 3: Theoretical pathways at the meso/community level linking low control and socioeconomic inequalities in health[8(p56)]



Last, at the macro/societal level, they provided two logic models that summarize different aspects/examples, one focused on gender discrimination (Figure 4) and the other on social breakdown during rapid socioeconomic transition (Figure 5).

Figure 4: Theoretical pathways linking women's low status in society to poorer health outcomes[8(p57)]

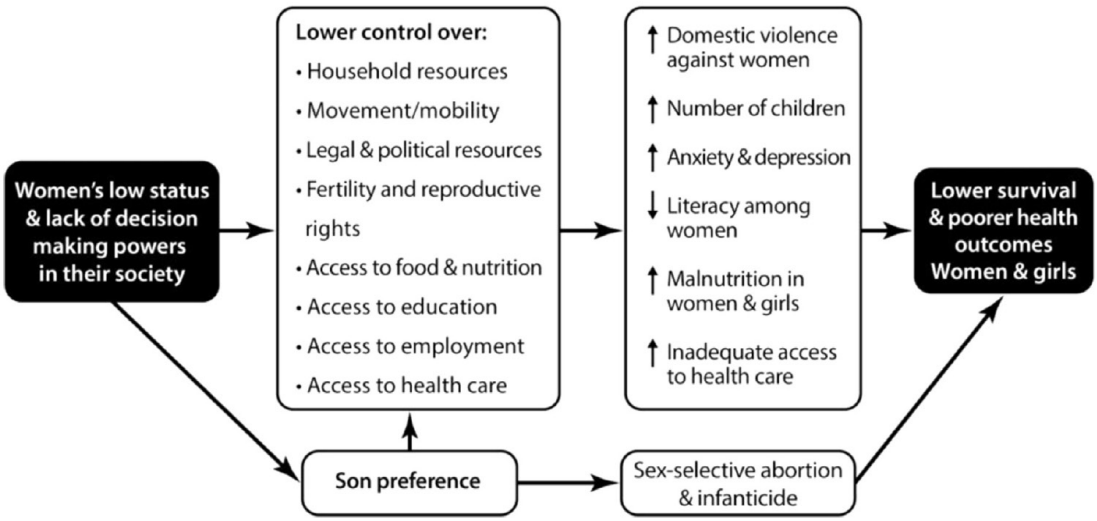


Fig. 3. Pathways from women's low status in society to poorer health outcomes.

Figure 5: Theoretical pathways linking traumatic societal transitions to poorer population health[8(p58)]

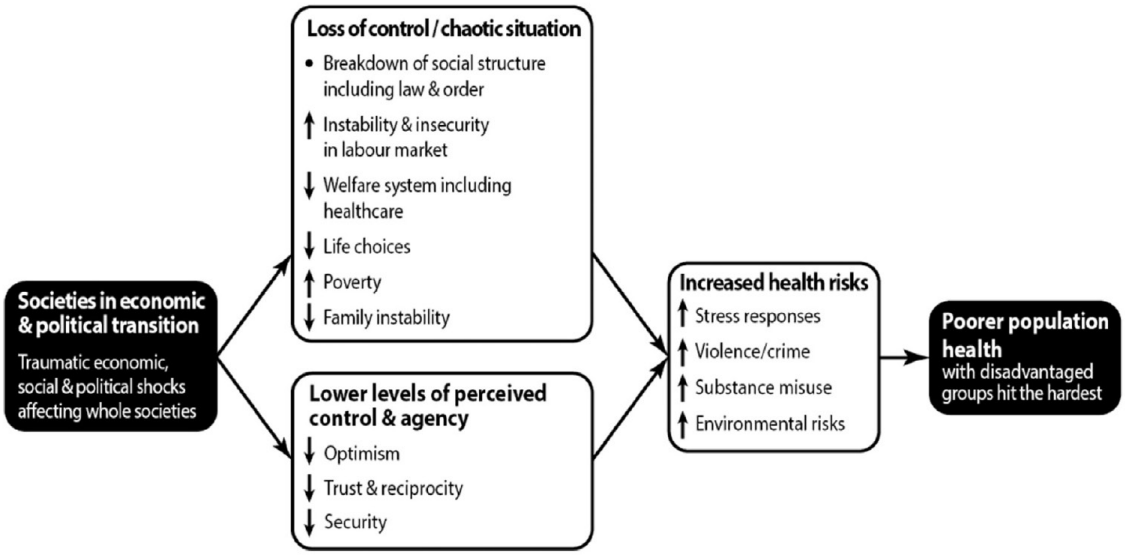


Fig. 4. Pathways from traumatic societal transitions to poorer population health.

We note that absent from the concept of control over destiny are other dimensions of power, such as power to influence world view. These discursive forms of power (e.g., that advance neoliberalism) also impact health at the macro/societal level. Furthermore, the models from Whitehead et al. leave out the concept that those currently with power influence policy and structures in ways that may negatively impact the health of others. Our evidence review covers aspects of these in two of the subsections below: Power concentrated in the hands of the few can lead to policies that lead to poor health outcomes, and, Political and economic systems, determined by power, influence health-related policy.

LITERATURE LINKING POWER AND VARIOUS HEALTH OUTCOMES

INDIVIDUAL POWERLESSNESS LEADS TO POOR HEALTH OUTCOMES

In 2002, Wallerstein[9] summarized the prior two decades of public health research related to power building. She concluded:

> In sum, these studies suggest that living in an environment of physical and social disadvantage – being poor, low in the hierarchy, under poor working conditions or being unemployed, subject to discrimination, living in a neighbourhood of concentrated disadvantage, lacking social capital, and at relative inequity to others – is a major risk factor for poor health. Being powerless or, in Syme's designation, lacking "control over one's destiny" therefore becomes a core social determinant.[p73]

Workplace settings

Initial research into individual power and health focused on workplace settings. Decades of studies have examined how health is influenced by "job latitude" or "job control" — the autonomy of an individual worker to make and influence decisions in the workplace, measured through standardized survey questions. Since the 1970s, researchers have conducted studies concluding that having less job control leads to, for example, more stress, more cardiovascular disease, worse self-rated health and more absences due to illness.[10–16]

Studies, including recent Canadian studies, have shown that some populations such as immigrants and temporary workers are at higher risk of occupational health and safety issues, at least partially as a result of lack of power in the workplace.[17–19]

As Muntaner et al.[20] summarized:

> A significant amount of published research has proved that workers in several risky types of labor—precarious employment, unemployment, informal labor, child and bonded labor—are exposed to behavioral, psychosocial and physio-pathological pathways leading to physical and mental health problems. Other pathways, linking employment to health inequalities, are closely connected to hazardous working conditions (material and social deprivation, lack of social protection and job insecurity), excessive demands and unattainable work effort, with little power and few rewards (in salaries, fringe benefits, or job stability). Differences across countries in the social contexts and types of jobs result in varying pathways, but the general conceptual model suggests that formal and informal power relations between employees and employers can determine health conditions.[p281]

Non-workplace settings

Evidence also demonstrates an individual's power over their life circumstances outside the workplace determines health outcomes. A recent systematic review by Orton et al.[21] concluded that "there is strong evidence from a small number of high-quality longitudinal studies that low perceived control in the living environment may play an important role in the pathways leading from low social position to poorer health and well-being."[p929]

Indigenous women in Canada

Moffitt[22] made the case that the colonization of Indigenous Peoples in Canada is a form of power and control that has been harmful for health, and that colonization is a determinant of health. She used forced separation of Dogrib Dene women from their families and communities during childbirth — and the powerlessness of individual women to refuse to be separated — as an example with poor birth outcomes. In the final report of the National Inquiry into Missing and Murdered Indigenous Women and Girls, colonial power is referenced repeatedly, as is the power of sexism and violence that has resulted from colonial power.[23]

A paper that investigated high sexually transmitted infection (STI) rates for Cree women in Canada found that:

> Abuse of power in relationships is causing physical, mental, emotional and spiritual wounds that disrupt the medicine wheel. Wounded individuals are seeking medicine to stop their suffering and find healing.... Many are accessing temporary (sex, drugs and alcohol) or permanent medicines (suicide) that relieve suffering but that do not heal. Others seek healing by participating in ceremony and restoring relationships (*wahkohtowin*) with self, spirit/religion, others, traditional knowledge and traditional teachings. Medicines that focus on suffering could increase STIs, while medicines that focus on healing could decrease STIs.[24(p20)]

BUILDING INDIVIDUAL POWER LEADS TO IMPROVED HEALTH OUTCOMES

A 2006 evidence review by Nina Wallerstein[25] for the World Health Organization (WHO) Regional Office for Europe's Health Evidence Network found that:

> Research on the effectiveness of empowerment strategies has identified two major pathways: the processes by which it is generated and its effects in improving health and reducing health disparities. Empowerment is recognized both as an outcome by itself, and as an intermediate step to long-term health status and disparity outcomes. Within the first pathway, a range of outcomes have been identified on multiple levels and domains: psychological, organizational and community-levels; and within household/family, economic, political, programs and services (such as health, water systems, education) and legal spheres. Only a few researchers have used designs resulting in evidence ranked as strong in the traditional evidence grading systems. Yet there is evidence based on multi-level research designs that empowering initiatives can lead to health outcomes and that empowerment is a viable public health strategy.
>
> Much research has been focused on empowerment of socially excluded populations (e.g., women, youth, people at risk for HIV/AIDS and the poor), though application of empowerment crosses to other populations and issues in public health. Youth empowerment interventions have produced multiple empowerment and health outcomes: strengthened self- and collective efficacy, stronger group bonding, formation of sustainable youth groups, increased participation in structured activities including youth social action and policy changes, leading to improved mental health and school performance. Multi-level empowerment strategies for HIV/AIDS prevention which address gender inequities have improved health status and reduced HIV infection rates. Women's empowering interventions, integrated with the economic, educational and political sectors, have shown the greatest impact on women's quality of life, autonomy and authority and on policy changes, and on improved child and family health. Patient and family empowerment strategies have increased patients' abilities to manage their disease, adopt healthier behaviours and use health services more effectively, as well as increasing care-giver coping skills and efficacy. Coalitions and inter-organizational partnerships that promote empowerment through enhanced participation and environmental and policy changes have led to diverse health outcomes.[p4]

Furthermore, a 2010 evidence review by Woodall et al.[26] noted that:

- "There is good evidence, from literature reviews and single studies, showing that empowerment interventions increase participants' psychological well-being, including self efficacy, confidence and self-esteem."[p12]
- "Evidence from one literature review suggests that participating in groups that share common interests can help individuals increase their sense of personal control in their lives."[p13]
- "There was some research evidence which demonstrated the link between empowerment and increases in knowledge and awareness."[p14]
- "Empowerment strategies focussing on high risk groups (sex workers, injecting drug users, men having sex with men who are not homosexually identified) have often adopted empowerment strategies and there is some evidence that these approaches can lead to behaviour change, including greater condom use which leads to reductions in HIV infection rates."[p14]
- "Only a few published studies were able to report any association between community participation and actual benefits in health."[p15]

Examples of more recent findings include:

- A 2016 systematic review of evidence about building women's power in the developing world identified:

  > Statistically significant associations were found between women's empowerment and maternal and child health outcomes such as antenatal care, skilled attendance at birth, contraceptive use, child mortality, full vaccination, nutritional status and exposure to violence. Although associations differ in magnitude and direction, the studies reviewed generally support the hypothesis that women's empowerment is significantly and positively associated with maternal and child health outcomes.[27(p119)]

- A study of a pilot power-building program for sex workers in a Canadian urban centre found that the program reduced internalized stigma and improved self-esteem; increased critical consciousness, participation and control, and resource mobilization; and strengthened solidarity.[28]
- Youth power building was shown to reduce suicide attempts, suicidal ideation and depression,[29] and to improve self-rated health.[30]

POWER CONCENTRATED IN THE HANDS OF THE FEW CAN LEAD TO POLICIES THAT LEAD TO POOR HEALTH OUTCOMES

Linking policy and health outcomes

While the literature described above directly associates health outcomes with individual power and powerlessness, the evidence about community power tends to associate it with policy and practice outcomes. Although policy and practice outcomes have been associated with health outcomes in other literature, the link becomes indirect, with policy and practice changes functioning as an intermediary.

A number of publications, summarized below, have explored how the power of corporations has led to public policies that can lead to poor health outcomes. We found, however, only one study looking at how others who have power (e.g., the wealthy) influence policy and health outcomes. Cushing et al.[31] reviewed social inequality by wealth and race, related power imbalances and environmental outcomes that are known to be linked to poor health outcomes. They found that there is stronger evidence that social inequalities and power imbalances influence air and water quality policies "that have more immediate health implications; evidence is less strong for more dispersed pollutants that have longer-term health impacts."[(p193)]

Corporate power

As Baum et al.[32] stated:

> A major challenge for public health in the twenty-first century is to respond to the changing dynamics of capitalist economies and the attendant impacts on people's daily living conditions, and ultimately health equity. Central to this process has been the growth in the power and influence of transnational corporations (TNCs). Since TNCs increasingly dominate global trade and investment and shape national economies, the adverse health and equity impacts of their practices are now fundamental influences on public health.[(p1)]

They provided a number of examples (reproduced below) of how transnational corporations have had positive and negative impacts on health:

> Examples of beneficial health impacts from TNCs include a range of shared value initiatives:
> - Mars (chocolate) engaging in sustainable cocoa initiatives through employing science, technology and certification to assist farmers through increasing yields and sustainable supply.
> - Nestlé adding micronutrients including iron and iodine to foods to improve health in impoverished regions.
> - BHP Billiton improving the quality and reliability of local suppliers through the "World Class Supplier Program" in Chile, leading to significant employment growth.

Examples of adverse health impacts from TNCs are:

- In 1998, at a time when the largest number of HIV/AIDS afflicted people lived in South Africa, 41 transnational drug companies sued the government of South Africa for initiating measures to reduce prices of anti-retrovirals.
- Coca Cola's depletion and pollution of groundwater in India to make a product with 10 teaspoons of sugar per serving, contributing to global epidemics of obesity and diabetes.
- In June 2009 an outbreak of E.coli food poisoning in the United States was linked to Toll House refrigerated cookie dough produced by Nestlé at a plant in Danville, Virginia. The company recalled all Toll House products in the country, but it came to light that the plant had previously refused to give inspectors from the federal Food and Drug Administration (FDA) access to internal records relating to matters such as pest control and consumer complaints.
- The 1984 toxic gas leak from the Union Carbide chemical plant in India, which included the loss of life of thousands of people in Bhopal where the community still suffers the aftermath and is campaigning for adequate clean-up, compensation and justice.
- Philip Morris Asia Limited sued the Australian government to repeal plain packaging laws despite the fact that 1 billion tobacco-related deaths are predicted globally this century.
- Tax avoidance strategies by McDonald's global operations have potentially cost European governments 1.0 billion Euros and the Australian Government $497 million dollars in unrealised receipts between 2009 and 2013 alone, reducing amounts government have to invest in health promoting infrastructure and services.
- Extractive industries have huge negative environmental and social impacts. Since the Australian TNC BHP began mining in Papua New Guinea in the 1980s, hundreds of millions of tons of waste have been dumped into the Tedi River causing irreversible damage to the river ecology and mass deforestation of surrounding areas and resultant health impact on Indigenous peoples.
- A narrative review indicated that pharmaceutical corporations suppress and misinterpret scientific evidence which leads to systematic overestimation of the safety and efficacy of products, and also exerts pressure on regulatory bodies against disclosure of adverse effects which are deemed to be "trade secrets".

These examples are indicative, but not exhaustive, of the scope of cumulative local, regional, national and global health impacts that potentially result from the activities of TNCs. They are also indicative of the ways in which the economic power of TNCs is likely to influence the pressures on governments and other stakeholders to make trade-offs between economic and social goals within processes of national development.[32(p3)]

Milsom et al.[33] reviewed evidence that corporate power influences the international trade regime and prevents policy action on non-communicable diseases. While they found that "the often hidden and invisible nature of power and non-decisions makes empirical analyses and drawing causal inference between processes of power and outcomes inherently very challenging,"[(p502)] their review is based on over 100 publications, including a number of studies from Canada. They observed:

- "Evidence indicates [transnational health-harmful commodity corporations (THCCs)] exercise instrumental power through their relationships (direct lobbying of trade policymakers) and rules (threats of trade rule violations or operating through governments to access legal mechanisms)."[(p502)]
- "Neoliberal-oriented institutional structures, practices and goals mean THCCs are often granted privileged access to trade and health decision-making spaces where their interests limit the scope of the agenda."[(p503)]
- "THCCs attempt to exercise agency over discursive power through reinforcing various framings of health issues in ways that resonate with neoliberal logic and values."[(p503)]

The authors also identified strategies to counter this use of corporate power.

Additional studies have examined the power of corporations in specific circumstances. For example, studies have looked at the power of:

- tobacco corporations and their impact on efforts to regulate and/or tax tobacco[34]
- food corporations and their impact on efforts to regulate and/or tax soda, ultra-processed food and fast food, and on nutritional policy broadly[35–41]
- the oil and gas industry in slowing the removal of lead from gasoline[42]
- a mining company and its ability to influence regulations that protect health[43]

BUILDING GROUP POWER AMONG THOSE FACING INEQUITY AND CIVIL SOCIETY POWER LEAD TO POLICIES THAT IMPROVE HEALTH OUTCOMES

Strong evidence exists that various forms of group power building among communities forced into marginalization and building civil society power lead to policy change that can then lead to improved health and health equity, though research has not directly connected building group power to health outcomes.[44] Below we summarize literature on various modes of building group and civil society power.

Joint decision-making

In *A systematic review of evidence on the impacts of joint decision-making on community wellbeing* — in which joint decision-making is equated with community members having some degree of power in decision-making — Pennington et al.[45] concluded that:

> The included studies provide evidence that joint decision-making interventions can be successful in helping to deflect threats to the local (living) environment and in resisting "hollowing out" of neighbourhood services and facilities, in maintaining and enhancing local conditions, and in attracting resources to create better places to live. There is also evidence that the interventions led to increased trust and reciprocity, control of anti-social behaviour, and power "with" community members to challenge unhealthy conditions. The beneficial impacts identified were on a wide range of established determinants of health and wellbeing (consistent with Dahlgren and Whitehead's socio-environmental model), including the physical conditions in which people live, social relationships, individual physical and mental health, community health, individual wellbeing, and community wide levels of wellbeing.[pp54–5]

They also found potential adverse impacts for those participating "associated with poorly designed and implemented interventions, involving insufficient support and guidance to public agency staff, community participants, and poor feedback and communication between public agencies and communities."[p55] They noted that the causes of these adverse impacts are amenable to change.

"Community empowerment"

Much has been written about the health impacts of "community empowerment" more broadly (i.e., not just in joint decision-making), where it has been defined as "a social action process by which individuals, communities, and organizations gain mastery over their lives in the context of changing their social and political environment to improve equity and quality of life."[46(p73)] The 2006 evidence review for the WHO Regional Office for Europe's Health Evidence Network found that:

> Community empowerment outcomes include community bonding measures – social capital, neighborhood cohesion, neighborhood influence, sense of community, community capacities or assets – community measures of participation, such as extent of civic organizations, and also objective changes in healthy public policies, transformed norms, greater equity, and improved material conditions. Community and national level empowerment variables within the political, economic, legal, and human rights sectors include good governance, institutional accountability, and women's

> empowerment. Good governance includes accountability of politicians and managers through an information flow to the public, enhanced civil liberties, lower corruption, and increased responsiveness of an institution to public health needs and problems, and reciprocal relationships with a public empowered with greater access to transparent information and control over resources. Civil liberties and community participation, which facilitate transparency, for example, have improved development effectiveness, increased expenditures in schools, and shaped health sector services, including increasing health centre attendance. Women's empowerment is measured at the national level by the percentage of women in political office and management positions and women's share of earned income; at the household level it is measured by land ownership, autonomy and authority in decision-making, mobility and levels of domestic violence.[25(p10)]

In recent years, a number of papers have been published about specific community power-building initiatives. Many of these focus on housing, and the Big Local initiative in England has been the subject of several case studies.[47–51]

Community-based participatory research

Community-based participatory research (CBPR) aims to equalize power relations between researchers and communities and build power with those communities.[52] CBPR is (as defined by the Kellogg Foundation's Community Health Scholars Program and quoted in Minkler et al.[53]):

> a collaborative process that equitably involves all partners in the research process and recognizes the unique strengths that each brings. CBPR begins with a research topic of importance to the community with the aim of combining knowledge and action for social change to improve community health and eliminate health disparities.[(p7)]

Multiple case studies have shown that CBPR has impacted health-related policies, including those related to healthy retail environments, criminal justice, environmental justice, goods movement, urban planning and education.[53–55] CBPR has also been shown to improve health behaviours and health outcomes.[56]

Community capacity

Community capacity can be defined as "the characteristics of communities that affect their ability to identify, mobilize and address social and public health problems"[57(p259)] and as "the cultivation and use of transferable knowledge, skills, systems and resources that affect community- and individual-level changes consistent with public health-related goals and objectives."[57(p259)] As such, the concept overlaps with community power building, though it is more limited. Community capacity building has been shown to lead to programs and policies that would improve health outcomes, for example, by increasing physical activity[58] and in environmental justice.[59,60] Popay et al. cautioned, though, that building power requires outwardly focused community capacity building ("onto political and social transformation for greater equity"), not only inwardly focused ("onto communities psycho-social capacities, lifestyle changes and proximal neighbourhood conditions").[2(p1254)]

Community and worker organizing

Community organizing (also called "grassroots organizing" and "base building") has been defined as "the process by which community groups are helped to identify common problems or change targets, mobilize resources, and develop and implement strategies to reach their collective goals."[61(p37)] Community organizers typically conceive of their work as community power building.[62–4] Community organizing focuses on policy and systems change related to determinants of health,[65] such as housing,[63,66] transportation,[65] immigration,[64] justice reform[67] and environmental issues.68 Health equity framing has also contributed to community organizing and power building.[69]

Similarly, worker organizing, through unions for example, has been shown to lead to better occupational health and safety.[20,70]

Civil society

More broadly, Anaf et al.[70] pointed out that civil society as a whole can build capacity to take on existing power structures, including transnational corporations, to advance equity. Civil society actors include unions and non-governmental organizations as well as informal groups of citizens. These actors often mobilize members of a community and use a variety of advocacy strategies, including product boycotts, shareholder activism, public protest or awareness-raising activities, disruption of company activities and legal action, or lobbying governments. These strategies have been successfully used by civil society organizations to win policy change.[70,71]

POLITICAL AND ECONOMIC SYSTEMS, DETERMINED BY POWER, INFLUENCE HEALTH-RELATED POLICY

At the macro/societal level, studies have analyzed the relationship between political and economic systems and health outcomes.

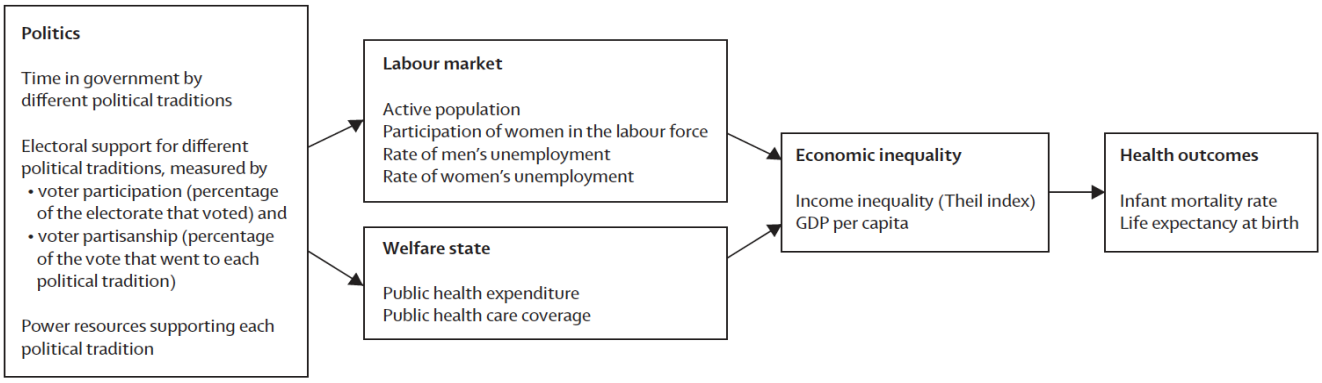
At the broadest level, Wise and Sainsbury[72] showed that democracy, which they defined as "a means of governance that was intended to equalize (at least more equitably distribute) political power across the citizens of nation states,"[p178] has led to improved health. Despite methodological shortcomings in the available literature, their review:

> found evidence that societies exhibiting, for instance, higher voter turnout at elections, more direct participation in societal decision making, or greater levels of political, economic and personal freedom, enjoy lower mortality rates at various ages, longer life expectancy and better mental health.[p181]

Similarly, countries with higher levels of "empowerment" — measured in terms of political rights and civil liberties — have longer life expectancies and lower rates of infant and under-five mortality.[73] In another sense, in a representative democracy, individuals cede some of their power to elected representatives. Those elected officials then hold "power over" the people who elected them on some issues but are charged with using that power to benefit the collective.

A number or authors have argued that power determines the political system and party in power, which determines economic and welfare policies, which determine poverty levels and economic inequalities, which, finally, determine health outcomes and inequities[74,75] (see Figure 6). When economic elites, including the corporate sector, hold power and dominate policy-making, more conservative governments are in place and health outcomes and inequities worsen.[76]

Figure 6: Linking politics and policies to health outcomes[74(p1036)]

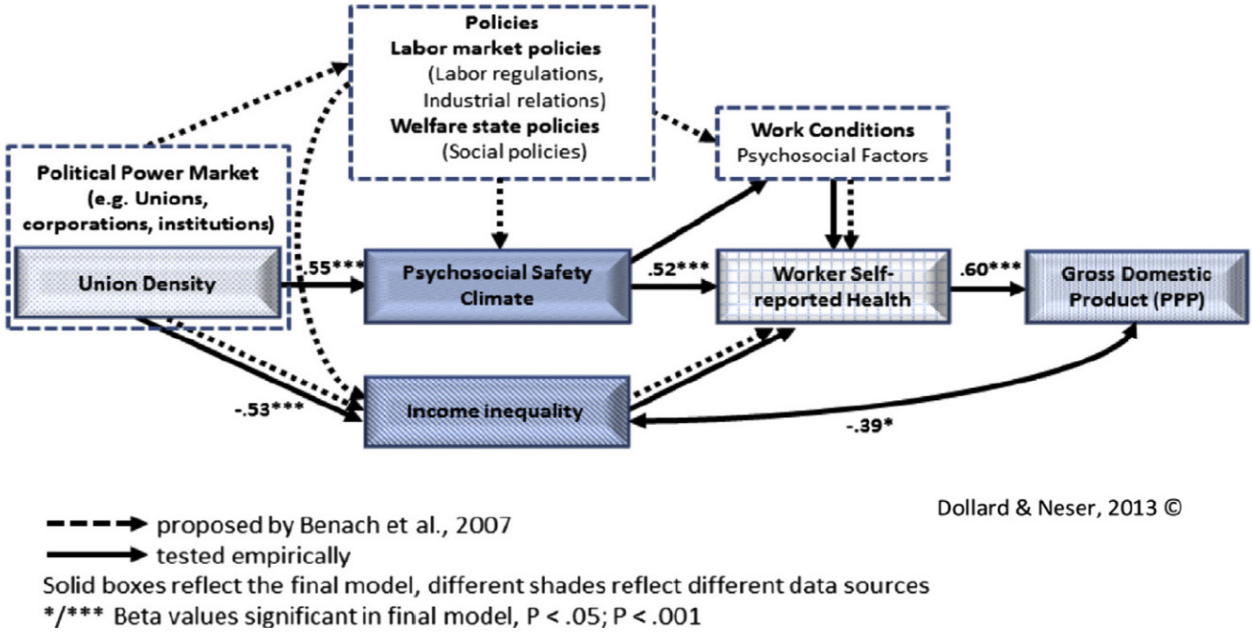


When working-class power is strong, health outcomes improve and inequities lessen.[77] Several studies show that the governments formed by political parties with more egalitarian ideologies (e.g., social democratic) tend to implement more redistributive policies than conservative governments, and the policies of those governments — including welfare state and labour market policies — improve health outcomes and reduce health inequities.[74,75]

At a more granular level, Dollard and Neser[78] showed that countries with more labour protections such as union density (i.e., social democratic countries) had better worker health. See Figure 7 for their model correlating worker self-reported health and gross domestic product using five data sets from 31 European countries. The results of their study:

> support a type of society explanation that social and economic factors (e.g., welfare regimes, work related policies) in concert with political power agents at a national level explain in part national differences in workplace protection … that are important for worker health and productivity.[p114]

Figure 7: National worker health productivity model[78(p116)]



In their literature review on political determinants of health, Beckfield and Krieger[79] found that:

> 1) the transition to capitalism (as observed in the 1980s and 1990s in Central and Eastern Europe) has probably expanded relative education-based health inequities; 2) neoliberal (market-oriented) reforms have either exacerbated or entrenched existing relative and absolute health inequities, and certainly have not reduced them; 3) within wealthy nations, the association between the type of welfare state and the magnitude of health inequities appears to be weak, especially for education-based inequity; and 4) democratic incorporation [political incorporation of subordinated racial/ethnic and Indigenous groups and women], if considered in relation to a long time frame, can lead to reduced relative and absolute health inequities.[p167]

They concluded that the balance of power between "disempowered groups (e.g., the labor movement, the feminist movement and the civil rights movement in the United States) and … persons with power"[p169] determines politics and policy and, therefore, health inequities.

Others have also detailed how neoliberalism — a current form of capitalism that "uses intersecting strategies including privatization, deregulation, tax cuts and austerity to restore the power of markets and capital to guide key economic and political decisions"[80(p25)] — is a source of health inequity, for example, through its impact on food, education, health care, work, transportation and social connection.[80]

CONCLUSION

In summary, the public health literature reviewed supports the following conclusions:

- Individual and group power have been linked to improved health, and individual and group powerlessness have been linked to poorer health. While group power is more relevant to changing the social determinants of health and equity, individual power and group power are intertwined. Building individual power is fundamental to group power building, and a group's building of power leads to building individual power, so both must be considered.
- When an unrepresentative few (e.g., corporate leaders) have excessive power in comparison to civil society, they can steer policy decisions, institutions and systems in ways — and create community conditions — that harm the health of some groups and maintain or increase inequity.
- When communities who have been marginalized and civil society build power, health outcomes improve.
- Democratic practices and political systems have also been tied to health outcomes. They can support people in decision-making to differing degrees and support particular ideologies that powerfully impact policy choices.

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