'Health equity through action on the social determinants of health': taking up the challenge in nursing

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Reducing health inequities is a priority issue in Canada and worldwide. In this paper, we argue that nursing has a clear mandate to ensure access to health and health-care by providing sensitive empowering care to those experiencing inequities and working to change underlying social conditions that result in and perpetuate health inequities. We identify key dimensions of the concept of health (in)equities and identify recommendations to reduce inequities advanced in key global and Canadian documents. Using these documents as context, we advocate a 'critical caring approach' that will assist nurses to understand the social, political, economic and historical context of health inequities and to tackle these inequities through policy advocacy. Numerous societal barriers as well as constraints within the nursing profession must be acknowledged and addressed. We offer recommendations related to nursing practice, education and research to move forward the agenda of reducing health inequities through action on the social determinants of health.

Key words: inequalities in health, nurse roles, population health, social determinants of health, social justice.

The WHO Commission on the Social Determinants of Health (CSDOH) was established in 2005 to develop strategies to narrow health inequalities worldwide. Its final report, *Closing the gap in a generation: Health equity through action on the social determinants of health* (World Health Organization (WHO) 2008), presents a new bold global agenda for health. Although health inequalities have been acknowledged for centuries, the concept has re-emerged in recent times. The recognition that health is not evenly distributed within and between countries was the impetus for the Alma Ata Declaration (WHO 1978) that ushered in primary health-care as the best way to achieve 'Health for all'. In the current era of globalization and increasing social inequalities worldwide, the need to reduce health disparities is again receiving attention with perhaps more urgency, as reflected in numerous international, regional and national initiatives, and a burgeoning academic literature. In Canada, the Federal/Territorial/Provincial Advisory Committee on Population Health and Health Security in 2004 launched the Task Force on Reducing Health Disparities to document the extent of health disparities, the factors leading to disparities and priority areas for their reduction (Health Disparities Task Group 2004). In 2007, the Canadian Standing Senate Committee on Social Affairs, Science and Technology established the Subcommittee on Population Health to examine the impact of social determinants of health on disparities and inequities in health among population groups. The committee's final report, *A healthy productive Canada: A determinant of health approach*, was recently released (Senate Subcommittee on Population Health 2009). The first *Report on the state of public health in Canada* (Public Health Agency of Canada 2008) by Canada's chief public health officer also focused on health inequalities. The second report (Public Health Agency of Canada 2009), focusing on children's health and development, continues to emphasize inequalities related to socioeconomic status and developmental

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opportunities. Moreover, health disparities are increasingly perceived as a social justice issue with ethical imperatives. A US scholar observes that 'health disparities have been declared the civil rights issue of the twenty-first century' (Wallace 2008, 34). Clearly, health disparities are a priority issue in Canada and around the world.

The gravity and complexity inherent in reducing health disparities calls for the involvement of diverse actors in government and civil society, and has significant implications for realizing the full scope of nursing practice at individual and collective levels. The purpose of this paper is to stimulate dialogue pertaining to nursing's role in reducing health disparities in light of the recent call for action. Although we focus on the Canadian context, the information is relevant for nurses in other countries, given evidence of health disparities worldwide. We begin with a brief analysis of the interrelated but distinct concepts of health disparities, health inequities and social inequities to explicate the underlying values and assumptions that guide this discourse. We provide a synthesis of recommendations to reduce inequities identified in recent international and Canadian documents, which we contend can invigorate and inform nursing's participation in reducing inequities. We present a nursing mandate informed by these recommendations, articulate fundamental prerequisites to realizing this mandate, and critically reflect on challenges both outside and within the nursing profession that need to be addressed to enable action on health inequities. Finally, we advocate specific strategies related to nursing practice, education and research that can assist the nursing profession to move forward the agenda of 'health equity through action on the social determinants of health'.

HEALTH DISPARITIES, HEALTH INEQUITIES AND SOCIAL INEQUITIES: UNPACKING THE CONCEPTS

Although the terms 'health disparities', 'health inequalities' and 'health inequities' are often used interchangeably, clarification of their differences is important because they reflect different perspectives on the 'causes' of health outcomes and hence point to different solutions. In this section, we argue that these terms differ in their underlying value orientations and assumptions and reflect differences in how health determinants are framed, and hence addressed. We conclude that the term 'health inequities' most clearly reflects a value orientation of social justice and most explicitly exposes the 'cause' of health disparities as rooted in societal structures.

The relatively neutral terms 'health disparities' and 'health inequalities' refer to differences in health status among population groups defined by specific characteristics (Health Disparities Task Group 2004). The nature and degree of health disparities can be empirically determined and constitute a core component of epidemiology. Populations that have been identified as being at risk for poorer health outcomes include: persons living in poverty, persons living with disabilities, ethno cultural minorities, sexual minorities, Indigenous peoples, persons living in rural and northern areas, women in precarious circumstances, immigrants and refugees, and persons with limited literacy. There is some consensus, however, that the most significant health disparities in Canada relate to socioeconomic status, Aboriginal identity, gender and geographic location (see Frohlich, Ross, and Richmond 2006 and Health Disparities Task Group 2004, for excellent reviews), and that Aboriginal peoples and people living in poverty are the most disadvantaged (Senate Subcommittee on Population Health 2009).

What accounts for ('determines') different health outcomes? The current discourse on determinants of health suggests that there are four broad health determinants: Personal attributes (biological and genetic endowment); health-care accessibility; acquired health behaviours; and social, economic, and cultural resources and environments (social determinants of health) (Lalonde 1974). For the most part, health professionals including nurses, have focused their interventions on health-care accessibility and acquired health behaviours. And although these determinants may indeed be proximal 'causes' of poor health, it is the social determinants of health (SDOH) – the material and social conditions in which people live – that are the most significant because they influence health directly as well as indirectly through the other determinants. SDOH identified in the *Toronto charter on the social determinants of health* include: early childhood development, education, employment and working conditions, food security, health-care services, housing shortages, income and its equitable distribution, social safety nets, social exclusion, and unemployment and employment security (Raphael, Bryant, and Curry-Stevens 2004). These determinants reflect the organization and distribution of economic and social resources (Raphael 2008). It is this understanding of what determines health that is foundational to the concept of 'health inequities' because it is public policies that determine the distribution of resources and therefore the quality of the SDOH. And it is the structure of society, including historical, political, economic and social factors that shape these policies.

The term 'health inequities' is now often used to refer to health disparities or health inequalities, particularly in

Canada, the UK and Europe, and more recently in the USA. The term 'health inequities', unlike 'health disparities' and 'health inequalities', however, more explicitly reflects a value orientation of social justice. Although health inequality/disparity is an empirical concept, describing what is and readily determined by epidemiological data, health inequity is a normative concept (Chang 2002), suggesting what could or ought to be. Health disparities then are more appropriately viewed as outcomes caused by inequities in those factors that contribute to health (Adelson 2005). When viewed as an outcome, health inequities are avoidable and unjust health inequalities (WHO 2008).

Significant scholarly work reflects attempts to elucidate the concept of health inequity. The most widely cited definition of health inequity was proposed by Margaret Whitehead (1992, 430) as 'differences in health that are not only unnecessary and avoidable but, in addition, are considered unfair and unjust'. Equity in health means that all persons have fair opportunities to attain their full health potential to the extent possible. The International Society for Equity in Health offered the following definition, emphasizing health outcomes: 'Equity in health is the absence of systematic and potentially remediable differences in one or more aspects of health across socially, demographically, or geographically defined populations or population subgroups' (Starfield 2006, 13). Braveman and colleagues elaborated this definition to also incorporate health determinants (Braveman 2006). Inherent in these definitions is the concept of the right to health and its prerequisites, enshrined in the UN Constitution and many other international agreements. Viewing health as a basic human right provides a strong moral (and even legal) obligation to ensure its realization.

Given that health inequity (or its converse, health equity) is a normative concept, some attention has been directed to determining when health disparities can be considered 'unfair' or 'unjust'. Whitehead (1992) identified four determinants leading to unjust health outcomes or health inequities: (i) health-damaging behaviours where the degree of choice of lifestyles is restricted; (ii) exposure to unhealthy, stressful living and working conditions; (iii) inadequate access to essential health and other public services; and (iv) health-related social mobility involving the tendency for sick people to move down the social scale. These conditions clearly reflect differences amenable to interventions. The CSDOH (WHO 2008, 4) elegantly states that 'where systematic differences in health are judged to be avoidable by reasonable action they are, quite simply, unfair'.

But what is the 'root cause' of this unfairness or injustice? Frohlich, Ross, and Richmond (2006) contend that health disparities are largely the result of (social) inequities in opportunities, resources and constraints, which produce unequal chances in life. They draw on Bourdieu's notion that social class groups have unequal access to various types of capital – social (networks, connections, institutional links), cultural (education, knowledge, history, family background) and economic (money, time, wealth) – that influence their abilities to prevent or ameliorate the origins and consequences of poor health. The importance of resources and various 'capitals' is further noted by Lynam (2005), who argues that marginalization limits peoples' abilities to access formal and informal resources and denies them opportunities to acquire competencies. Link and Phelan (1995) also point to social inequalities as the underlying determinant of health disparities. Their influential work on the 'fundamental social causes' of health and disease suggests that knowledge, power, prestige and social connections are among the social factors that shape health outcomes. These social resources then are *the* key determinants of health. The CSDOH (WHO 2008, 1) points out that health inequities result from the 'unequal distribution of power, incomes, goods, and services, globally and nationally'. The societal structures that underlie the (unequal) distribution of resources (and hence social inequalities) are economic, political and ideological (see Grabb 2002), and are reflected in public policies.

Linking social inequalities to health outcomes reflects a critical/structural approach to health that incorporates political economy (Bryant 2009). An SDOH perspective framed around a political economy approach explicitly exposes the 'causal chains [that] run from macro social political and economic factors to the pathogenesis of disease' (Blas et al. 2008, 1685). In short, 'how a society produces and distributes societal resources among its population – that is, its political economy – are important determinants of population health' (Raphael and Bryant 2006, 238).

The key elements that constitute health equity are summarized in table 1. Our reflection on these elements leads us to advocate for the use of the term 'health inequities' rather than 'health inequalities' or 'health disparities' when the elements that constitute health equity or inequity are implied. We maintain that the use of 'health inequalities' or 'health disparities' in such instances can obfuscate the fundamental cause of health disparities as embedded in societal structures and policy decisions, and mask the ethical principle of social justice, which provides the moral imperative to address the causes.

Table 1 Fundamental understandings of health equity

Health equity reflects the principle of social justice or fairness related to equitable allocation of 'resources' in the broadest sense.

Health equity is based on a human rights perspective, including the right to health and its prerequisites, the right to participate fully in society, and the right to non-discrimination.

Health equity includes equitable access to health-care and the social determinants of health.

Social, economic, material, cultural, and political structures are key determinants of health.

Health equity is shaped by policies. Achieving health equity is ultimately a political process.

Achieving health equity requires an intersectoral approach (beyond that of the health sector).

RECOMMENDATIONS ADVANCED TO REDUCE HEALTH INEQUITIES

To set the context for a more focused discussion on the nursing role in reducing inequities, we identify recommendations and directions that have been articulated in key documents globally and nationally, summarized in table 2.

A review of these recommendations reveals that although there are differences in focus and emphasis across these documents, based in part on the jurisdictions for which they were developed (Canadian or global), there are several common themes. First, all of the documents point to the need to strengthen the knowledge base on disparities and their effects, including evaluation of initiatives aimed at reducing disparities. Second, leadership at the highest levels of government using a whole of government approach is strongly advocated, beginning with the development of health goals (including indicators and targets) for reducing disparities.

Health impact (or even health disparity impact) assessment of all policies is consistently emphasized because health determinants are broad and the purview of many government departments. This 'health in all policies' approach has been implemented in many jurisdictions and is required by law in others (e.g. Quebec, Sweden and New Zealand; Senate Subcommittee on Population Health 2009). A third common theme emphasized in the documents is the call for collaboration across government sectors, between government levels, and with non-governmental partners, that also gives voice to marginalized populations and engages communities in meaningful ways. The role of these different actors and multiple stakeholders warrants further discussion, as herein lies the solution to reducing inequities, while presenting one of its key challenges.

Of the documents reviewed in table 2, the CSDOH and Senate Subcommittee are particularly strong in their emphasis on the role of the state because inequity is 'systematic,

Table 2 Key recommendations for reducing health disparities

Health Disparities Task Group (2004)	Make health disparities reduction a health sector priority
	Integrate disparities reduction into health programmes and services
	Engage with other sectors in health disparities reduction
	Strengthen knowledge development and exchange activities
Report on the State of Public Health in Canada (2008)	Foster collective will and leadership: demonstrate leadership, develop knowledge infrastructure, take intersectoral action
	Reduce child poverty: make social investments
	Strengthen communities: build community capacity
WHO Commission on the Social Determinants of Health (2008)	Improve daily living conditions
	Tackle the inequitable distribution of power, money and resources
	Measure and understand the problem and assess the impact of action
Senate Subcommittee on Population Health (2009)	Establish a new style of governance – a whole of government approach
	Develop a population health data infrastructure with longitudinal capacity to monitor, evaluate and report on well-being
	Build healthy communities through initiatives that integrate education, health and social services
	Develop and implement a pan-Canadian population health policy to address First Nations, Inuit and Métis peoples

produced by social norms, policies, and practices that tolerate or actually promote unfair distribution of and access to power, wealth, and other necessary social resources' (WHO 2008, 14). Blas et al. (2008), using evidence from the Knowledge Networks of the CSDOH, identify three vital roles for governments: (i) ensuring provision of basic services, and promoting human rights and the right to a decent standard of living, thereby fostering more equitable distribution of resources; (ii) developing legislative and regulatory frameworks to influence the actions of others; and (iii) monitoring health status. These roles clearly and explicitly acknowledge the fundamental cause of inequities as inequitable distribution of resources rooted in government policies.

Non-governmental players (i.e. civil society) including informal community groups, formal organizations and social movements are also crucial to reduce health inequities. Blas et al. (2008) argue that the beneficiaries of equitable policies have a right to participate in their design, delivery and evaluation. Formal social organizations (where we would include professional organizations and health-care agencies) have a role in advocating, monitoring, mobilizing communities, providing technical support, and training and giving voice to marginalized peoples. Nevertheless, these authors caution that civil society involvement is contingent on state support to foster democratic engagement, again emphasizing the primacy of government. We agree with Baum's (2007) insightful analysis that achieving health equity requires action from politicians and senior policy-makers (top down) and community action from civil society (bottom up). She argues that governmental policies to reduce social inequities are driven by a belief in social justice, and that this belief can be nurtured by bottom-up pressure from civil society actors, including advantaged groups such as professional organizations and associations. We contend that nursing professional organizations, as part of civil society, need to heed this call in a more concerted and purposeful way.

THE NURSING MANDATE

Promoting social justice and health equity fits well with nursing's historical and philosophical roots. Cathy Crowe, a Toronto street nurse who advocates for the homeless, succinctly summarizes this nursing legacy: 'Throughout our history, it has been nurses who, after witnessing injustices, spoke out. They responded with words, with research, with action, with the development of programmes, with legal action, and with new policy proposals' (Crowe 2006). Most recently, Villeneuve (2008) called on nurses globally to make elimination of disparities the core goal of nursing for the twenty-first century. The mandate for this work is identified

in international and Canadian documents. For example, the International Council of Nurses (ICN) has advanced nursing's position in tackling disparities through its 'fact sheets' on numerous social determinants. In Canada, the Canadian Nurses Association (CNA) has produced several documents and position papers such as *Social determinants of health and nursing* (CNA 2005), *Social justice … a means to an end, an end in itself* (CNA 2006), *Determinants of health* (CNA 2009) and the *Code of ethics* (CNA 2008), all of which support to some degree a role for nursing in addressing health disparities brought about by inequitable social conditions. However, it is the Community Health Nurses of Canada (CHNC) that provides the strongest mandate in this regard. CHNC has identified the reduction of health disparities arising from social inequities as one of the practice standards (and hence a requirement) for community health nursing practice (CHNC 2008), and more recently has explicated competencies (e.g. policy development and advocacy) required to meet this standard (CHNC 2009).

Nurse scholars have for some time emphasized the need to address the root causes of health inequities by focusing on the social conditions that produce them (e.g. Butterfield 1990; Drevdahl et al. 2001; Falk-Rafael 2005; Lynam 2005; Cohen and Reutter 2007, 286). Smith (2007) goes so far as to say that 'nursing is the health profession *best* suited for leadership in reducing disparities'. She argues that nursing and health disparities are 'inextricably linked by their very natures', because caring is the essence of nursing and 'health disparities are, fundamentally, the result of lack of caring within society'. We believe that the documents (table 2) provide a strengthened mandate and direction to advance nursing's role in reducing health inequities. We contend that the overarching mandate of nursing in addressing health inequities is to ensure access to health (and its determinants) and health-care. This mandate requires a two-pronged nursing approach: (i) providing sensitive empowering care at the individual/community level to those experiencing inequities, and (ii) working to change the environmental and social conditions that are the root cause of these inequities. To realize this mandate, nurses will need to invoke a 'critical caring approach' (Falk-Rafael 2005) to understand the context of inequities and to tackle inequities through policy analysis and advocacy (see fig. 1).

Understanding the context of health inequities

The context of health inequities includes their nature and extent, the factors that contribute to inequities and how these inequities are experienced. Such a perspective requires 'emancipatory knowing' as articulated in Chinn and
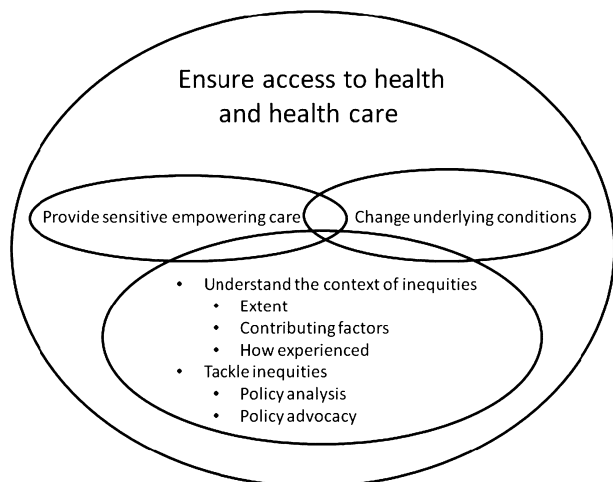
Figure 1 Nursing mandate to promote health equity

Kramer's (2008) re-conceptualization of Carper's ways of knowing, and founded on critical social theory. Emancipatory knowing is:

> the human ability to recognize social and political problems of injustice or inequity, to realize things could be different, and to piece together complex elements of experience and context in order to change a situation as it is, to a situation that improves people's lives. (Chinn and Kramer 2008, 77)

Emancipatory knowing is congruent with a critical/structural approach to health (Bryant 2009), incorporating a political economy perspective to emphasize historical, social, economic and political factors that lead to social inequalities and ultimately health inequities.

The nature and extent of health disparities is readily available in many excellent formats, using regional, national and international data. There is increasing evidence on the social determinants of chronic illnesses (e.g. cardiovascular, diabetes, mental illness), personal health practices (e.g. physical activity, nutrition) and access to quality health-care. Beyond the knowledge of 'what is', however, nurses will require a more critical understanding of the political and social factors responsible for health inequities (the 'why'). These factors include the policies and conditions most likely to support (or not) the SDOH; contextual factors, including globalization, in the creation of health (in)equities globally and nationally; and the political forces that influence the size and quality of the welfare state, which is deemed critical to achieving more equitable health outcomes. There are many thoughtful analyses available, including cross-country comparisons, that point to key political and economic forces that support health-enhancing public policies (see Bryant 2006). Such knowledge is important in determining the receptiveness of governments to a social determinants perspective,

and ultimately in strategizing advocacy efforts (Bryant 2009). The population health discourse in Canada has not considered to any great extent the political economy approach in spite of its promise as the most 'upstream' approach to tackling health inequities (Raphael and Bryant 2006).

Understanding the context of inequities also implies the appreciation of how these inequities are experienced by vulnerable populations and communities in their day-to-day lives because although the root causes of health inequities are structural, their effects are experienced at a personal level. Nurses witness these effects in their daily interactions with clients. Sensitive empowering assessments that incorporate SDOH at individual and community levels can lead to a better understanding of needs, constraints and challenges in designing appropriate nursing interventions (CNA 2005). Understanding what it is like to live with inequities can also be gleaned from qualitative research that gives voice to vulnerable populations and uncovers the contextual factors that impact individual-based risk factors, health and health-care. These 'emic' perspectives reveal more clearly the resourcefulness and resilience of vulnerable populations and can invalidate the myths and stereotypes that lead to discriminatory and stigmatizing practices that ultimately maintain inequities (Reutter et al. 2009).

Tackling health inequities

Tackling inequities to ensure access to health and health-care requires action at various levels. Nurses have for the most part engaged in working with individuals and families to alleviate the effects of inequities, and certainly must continue to do so. An understanding of the broader context of their clients' health situations, as outlined above, should result in more sensitive, nonjudgmental care, as insensitivity often reflects inadequate understanding of the current and historical context of people's lives and the structural factors impinging on their health situations. To alleviate and prevent the effects of inequities, nurses must continue to assist individuals and families to secure appropriate health-related services and supports. Research reveals that for people living in poverty, for example, services may be financially, geographically and culturally inaccessible, of inferior quality, and less than compassionately and respectfully delivered, and that people are often unaware of services available to them (Stewart et al. 2005; Reutter et al. 2009). Similar findings of inadequate services have also been reported for other vulnerable groups, such as immigrants (Asanin and Wilson 2008), Aboriginal peoples (Browne and Fiske 2001), and those with stigmatizing social or medical conditions (Pauly 2008). These researchers point out that although nurses

work to remedy some of these inadequacies within their own agencies, these interventions at the individual, family and even community level do not address the root causes of these health inequities.

Given that SDOH and the policies that enable them are at the root of inequities, policy advocacy is *the* key strategy to reduce inequities. Raising awareness of the SDOH among the public, policy-makers, practitioners and health professionals is a first step in policy advocacy. In essence, this is a step towards building 'emancipatory knowledge' among those who can effect change, and posing the 'difficult' questions that probe the root causes of inequities. Consciousness-raising includes policy analysis that explicates how ideologies of governing parties shape the quality of social determinants. Monitoring strategies such as collecting and presenting stories of the impact of policies on people's lives can also be used to raise awareness of inequities (Cohen and Reutter 2007). Nurses are well positioned to be leaders in this consciousness-raising, given their involvement with clients in their day-to-day lives at the intersection of the 'personal and political.'

Policy advocacy includes advocacy not only for more equitable health-care but also, more importantly, for improved living and working conditions. In relation to socioeconomic inequities, for example, this means advocating for such policies as 'living' wages and adequate government income support, affordable housing, quality child care and early childhood education, fair employment, and universal comprehensive social protection, to name a few. As pointed out in table 2, policy advocacy is best addressed through intersectoral collaboration and working in partnership with other stakeholders including the beneficiaries of these policies. An interesting example of interdisciplinary advocacy is the Health Providers Against Poverty group in Ontario, comprised of physicians, nurses, nurse practitioners, dietitians, health promoters and others. This group, one of whose founding members was a nurse practitioner, has a fourfold mandate of education and outreach to raise awareness of poverty as a determinant of health, advocacy, research and direct action. Professional (nursing) organizations also have great capacity for policy advocacy because of their organizational infrastructure, networks and political know-how, as well as their strength in a large and diverse membership. They can forge alliances with other advocacy organizations and associations to strengthen lobbying efforts. For example, the Dignity for All initiative for a poverty-free Canada (http://www.dignityforall.ca) comprised many individuals, organizations (including professional associations of teachers and social workers, Registered Nurses Association of Ontario (RNAO)) and 'grassroots' advocacy groups.

BARRIERS TO ADDRESSING HEALTH INEQUITIES

Complex barriers at the societal level and at the level of the nursing profession influence and constrain the potential to alter the social conditions that lead to health inequities. A major barrier at the societal level in many western democracies including Canada is the ideology of neo-liberalism (Collins and Hayes 2007; Raphael, Curry-Stevens, and Bryant 2008). Briefly, this ideology focuses on the dominance of markets and a retreat from government intervention, resulting in privatization of services, limited universal social protection programmes and individual rather than collective responsibility for the welfare of the population (Raphael, Curry-Stevens, and Bryant 2008). All of these factors have been implicated in health inequities and poorer health outcomes, and constitute barriers to 'tackle the inequitable distribution of power, money, and resources' (WHO 2008, 2). In Canada, there are also constraints arising from the structure and organization of governmental departments, with policy silos that make intersectoral work and 'health in all policies' more difficult (Collins and Hayes 2007). Within the health sector itself, the major proportion of funding goes to clinical care, which legitimizes a treatment approach to disease rather than addressing causes of ill health rooted in social inequalities (Collins and Hayes 2007). Moreover, the federal system of government with responsibilities for health determinants divided among provincial/territorial and national governments makes inter-governmental collaboration more challenging.

The dominant ideology of individual responsibility for health is another barrier, as it shifts attention from the SDOH to individual behaviours and health-care as the main determinants of health (Collins and Hayes 2007; Niederdeppe et al. 2008; Raphael, Curry-Stevens, and Bryant 2008). The deeply entrenched biomedical and behavioural/ lifestyle discourse presents challenges to raising awareness of the SDOH (Browne and Tarlier 2008; Niederdeppe et al. 2008; Raphael, Curry-Stevens, and Bryant 2008), particularly when the health sector also focuses programming in these areas (Frankish et al. 2007). Moreover, the media perpetuates this behavioural and health-care focus in Canadian health reporting (Gasher et al. 2007; Hayes et al. 2007), which is particularly significant given the influence of the media on the public, policy-makers and even health professionals (Reutter et al. 2004, 2005; Collins and Hayes 2007).

In addition to these societal barriers, there are factors within the nursing profession that may be problematic. A fundamental challenge that mitigates against realization of the broad scope of nursing practice is the emphasis on the 'nurse–person relationship' rather than on a population health approach that calls for interventions at a collective (policy) level (Falk-Rafael 2005; Spenceley, Reutter, and Allen 2006). This individual focus is evident in nursing frameworks and models, most of which incorporate a very proximal view of environment that does little to extend the gaze to broader social conditions as targets for nursing interventions, and may contribute to the perception that advocating policy is outside the scope of nursing practice. Moreover, the internal divisions in nursing practice (e.g. between community health and acute care) may discourage collaboration among nurses to present a united voice (Spenceley, Reutter, and Allen 2006). Attention to the SDOH, health (in)equity and policy advocacy have been viewed as the purview of community health nurses because of their population health focus; however, all nurses need to look beyond the immediate to address the inequities that give rise to their clients' health situations.

Inadequate knowledge and skills or lack of political competence has been identified by many nurse scholars as a key barrier to engaging in policy advocacy (see MacDonald and Schoenfeld 2002; Reutter and Duncan 2002; Deschaine and Schaffer 2003; Spenceley, Reutter, and Allen 2006; Cohen and Reutter 2007; Browne and Tarlier 2008). Interventions at the policy level require skills in policy analysis and in policy advocacy. Bryant, Raphael, and Rioux (2006) maintain that, for the most part, health science professionals in general receive little education in public policy analysis, yet an understanding of the policy change process in particular is crucial for those advocating for health. There is very little research by nurses about how to do policy advocacy and few conceptual models to guide this work. Spenceley, Reutter, and Allen (2006) discuss how nursing can begin to utilize the knowledge of other disciplines to inform their work. For example, social policy scholar Toba Bryant's (2009) framework of policy change is particularly germane, given its congruence with nursing values and aims. Bryant incorporates a critical analysis of the ways of knowing used in policy advocacy, and focuses on the importance of a collaborative advocacy approach among policy professionals, citizen activists and other practitioners. Such an approach clearly exemplifies the role of both government and civil society in reducing health inequities.

There are also challenges to policy advocacy emanating from nurses' employment situations. Nurses report heavy workloads carrying out mandated clinical services that leave little time for policy advocacy, even in community health nursing (MacDonald and Schoenfeld 2002; Cohen and Reutter 2007). Workplaces that do not commit to addressing the SDOH (and the consequent role of policy advocacy) pose barriers for nurses. If the organization itself does not model efforts to reduce inequities through policy action, then it is difficult for nurses to enact this role, even if they have the knowledge and skills. The support and endorsement of health agencies also lends credibility to the advocacy efforts of individual health professionals (Raphael, Curry-Stevens, and Bryant 2008). Overall, the record for health regions in Canada in this regard is quite dismal, in spite of encouraging signs in some jurisdictions (Raphael 2003, 2009a; Lessard and Raynault 2009). Why health agencies whose raison d'être is the promotion of health have not more forcefully engaged in policy advocacy to enable health is somewhat perplexing. It has been suggested that health agencies may be reticent to challenge government policies that maintain inequities when these agencies depend on government funding (Raphael 2003). Nurses employed in these agencies may also not feel safe to advocate for changes that are perceived to jeopardize their careers (Raphael 2009b).

Although nursing organizations in their documents advocate and therefore legitimize a role for nurses in reducing inequities, most nursing associations in Canada tend to emphasize health-care policy rather than healthy public policy that impacts SDOH and is therefore more likely to reduce health inequities (Cohen and Reutter 2007). The RNAO is an exception in their advocacy for healthy public policy such as increases in welfare incomes and minimum wage, and most recently in their submission to Bill 152, the Poverty Reduction Act 2009 in Ontario (see RNAO website). Nevertheless, several Canadian nursing associations have excellent political advocacy tools on their websites to assist nurses with their individual lobbying efforts. The inconsistencies between nursing organization documents and action taken to move beyond an emphasis on the individual nurse–patient relationship have been identified in other jurisdictions (Bekemeier and Butterfield 2005). If nursing organizations were more involved in policy advocacy to reduce root causes of health disparities, then individual nurses might be inspired to engage in this role both as citizens and as members of the profession.

MOVING FORWARD

Despite these many challenges, moving forward to 'close the gap' of health inequities must be a priority for nursing practice, nursing education and nursing research. We believe that there are promising signs of moving forward. Nurses in both

community health and acute care settings have identified that nursing's scope of practice needs to be extended to target the social conditions leading to disparities, and that this will require building political competence to enable policy advocacy (Rains Warner 2003). A recent promising development is the creation of the journal, *Policy, Politics, and Nursing Practice*, which legitimizes political advocacy as a nursing role. Nursing undergraduate curricula are incorporating SDOH and social justice concepts (Cohen and Gregory 2009), and policy courses are being offered in graduate programmes (e.g. Reutter and Duncan 2002). Nevertheless, the barriers identified above suggest further areas for development.

Curricula at both undergraduate and graduate levels must assist nurses to 'develop a more critical, politicized stance' (Browne and Tarlier 2008) that incorporates a political economy approach to understanding SDOH. A stronger emphasis is needed on reducing inequities rather than only alleviating their effects, which will require competence in policy level interventions. Courses that focus exclusively on policy analysis and advocacy, particularly at the graduate level, are critical, because they convey the complexity and significance of this body of knowledge and, when delivered in an interdisciplinary environment, can be particularly enriching (Reutter and Duncan 2002). Policy courses in the health professions have tended to focus on health-care policy and must be extended to incorporate public policy that addresses the SDOH outside of the health-care system. Core courses should be augmented with a social justice/equity and policy lens throughout the curriculum. At the undergraduate level, students can be challenged to identify policy implications related to individual client health situations, by posing questions such as: Who is most at risk for poor health outcomes? Why is this so? What policies contribute to the health situation of this client? Why are these policies in place? Who benefits? And what is nursing's role in advocating more health-enhancing policy options? In short, we believe that nursing curricula require greater integration of a political economy approach both to understand the context of inequities and to tackle health inequities.

There is also a need for further research focused on reducing health inequities. We concur with the documents (table 2) that more epidemiological studies may be needed to identify the extent of disparities and the pathways through which social inequities lead to poor health outcomes. Understanding the pathways that link social inequities to health may afford extra opportunities to intervene (often to lessen the negative effects of social inequities; Lynch 2007); however, researchers need to heed the caution of Link and Phelan (1995) that understanding ever more proximal intervening links (e.g. individually based risk factors or behaviours) will not help to understand or change the distal factors or underlying social conditions. 'If one genuinely wants to alter the effects of a fundamental cause, one must address the fundamental cause itself' (Link and Phelan 1995, 88). Critical analyses of the factors that contribute to this fundamental cause (the 'causes of the causes') are needed, which points to the need for policy research in nursing.

Policy analysis as a form of nursing research is relatively uncommon, yet a more fulsome understanding of policy – its processes, contexts, and content – could inform our advocacy efforts as we explicate the links between evidence and policy (in)action. Duncan and Reutter (2006) draw on several theorists to propose a critical approach to policy analysis. Briefly, a critical analysis (i) directs attention to exposing connections between context, process and content – how this interplay influences the definition of policy problems, agenda setting, and choice of policy instruments; (ii) exposes the ideologies and values underlying policy issues and their proposed solutions, and the inclusiveness (or not) of the policy debate – how other actors understand and frame the issues; and (iii) exposes the reality of organization processes – how policies are experienced by people in their daily environments. Policy analysis research that compares policies and their effects on health inequities across different jurisdictions (both within and across countries) is particularly powerful as it provides evidence that inequities are not inevitable but instead emanate from social policies that determine inequitable distribution of resources. The Public Health Agency of Canada (2008, 2009) Reports, for example, cite successful government initiatives from the UK, Finland, Norway and elsewhere that have resulted in reduced poverty rates. It is instructive to analyse which types of governments are more likely to provide for the SDOH (i.e. political economy) and hence to reduce health inequities.

Researchers also need to determine policy advocacy best practices. Raphael (2009b) argues that research is needed on why policy advocacy related to the SDOH has been relatively ineffective. Effective policy advocacy by organizations could fruitfully be studied to determine strategies used, factors influencing success and lessons learned. Spenceley's (2007) study of the Canadian Diabetes Association and Bryant's (2002) comparison of two different organizations are excellent examples of the value of this type of research for theory development and for informing advocacy efforts. Spenceley's work, elaborating on Bryant's model, explicated how interactive, instrumental and critical knowledge comprises the strategic knowing that is necessary for effective policy advocacy. Studies that evaluate policies and programmes for their impact on health and health-care, incorporating a health impact assessment approach, could also strengthen

advocacy efforts, as would demonstration projects of new initiatives that aim to decrease social and health inequities.

Because health inequities ultimately result from the attitudes, beliefs and actions of those who are not experiencing inequities (yet have the power to change conditions), research that examines how advantaged groups view the situations of those who are vulnerable may also be beneficial to raise awareness and to inform policy advocacy agendas. Knowing what the public thinks can focus advocacy efforts to change attitudes – often the precursors of personal and institutional discrimination, which are both cause and consequence of inequities (Reutter, Harrison, and Neufeld 2002). Professional attitudes and beliefs clearly influence inequities in health-care delivery – the types of services provided, how they are provided and advocacy efforts. Very limited research has identified the perspectives of policy-makers and politicians regarding SDOH such as poverty, which is another potentially fruitful avenue of knowledge development. Such data could be used in advocacy aimed at policy change.

CONCLUDING COMMENTS

The emergent global agenda of reducing health inequities provides both new opportunities and challenges for the nursing profession. Tackling health inequities is clearly within the nursing mandate, yet this role is underutilized within nursing's scope of practice. Societal barriers and constraints within the nursing profession pose considerable challenges. Key global and national documents can inform nursing initiatives related to practice, education and research. Most critical to moving forward this agenda is engagement in policy advocacy initiatives. We propose that nursing curricula incorporate a political economy approach to understanding SDOH to better prepare nurses to engage in policy analysis and advocacy. Knowledge development in nursing needs to be expanded to incorporate policy analysis and policy advocacy best practices. Nursing organizations play a critical role not only in supporting individual nurses in their advocacy efforts, but also in working collaboratively with citizens, other organizations and governments to realize 'health equity through action on the social determinants of health'.

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