Alternate Routes: A Journal of Critical Social Research, 36(1), 156-166 (2026)

What Would Real Engagement by the Canadian Public Health Community in the Politics and Structural Determinants of Health Involve? A Response to Recent Papers in the *Canadian Journal of Public Health*

Dennis Raphael[1] and Toba Bryant[2]

ABSTRACT: Two recent commentaries in the Canadian Journal of Public Health call for the public health community to address the political and economic determinants of health. Ronald Labonté urged the Canadian public health community to stop its political fence-sitting and take seriously the politics of health. Lindsay McLaren and Elizabeth McGibbon called for the public health community to engage in addressing the structural determinants of health. These sentiments are not new having been expressed in Canada since at least 1986 with little evidence of governmental response. In this commentary we identify and discuss different forms of engagement and why to date such engagement by the Canadian public health community has been limited to apolitical forms of rhetorical exhortation rather than critical analysis of the role the state plays in producing public health within neoliberal capitalist formations. As such, these exhortations will prove to be ineffective as the likelihood of public health moving towards critical analysis seems unlikely under current conditions. The primary reason for this depoliticization of health issues is that traditional public health institutions and many public health researchers are embedded within the very same governing structures whose public policies create the health threatening living and working conditions – the social determinants of health -- public health aims to address. We call for a broader social movement – that could involve the public health community -- to challenge existing power relations under neoliberal capitalism that make achieving Health for All almost impossible to achieve.

KEYWORDS: Public Health; Health Equity; Social Movements; Capitalism; Neoliberalism; Social Determinants of Health

Introduction

Long-time public health academic and activist Ronald Labonté (2024) recently called for the Canadian public health community to engage with the politics of health. Evoking the spirit of Rudolph Virchow, Labonté argued "ideological and power-relational structures of capitalism (neoliberal or otherwise) are still only rarely addressed [by the public health community] for the health deprivations they create" (2). His call for action is worth quoting in full:

> As our world stumbles under the weight of climate catastrophe, wealth inequity, xenophobia, and the intersectional 'isms' of class, gender, race, and sexuality, and with the rising risk of geopolitical conflicts becoming global war, it is past time for public health to stop straddling the divide of two political economies. We need not discard the proficiency and concerns of those of Chadwick's public health

[1] **Dennis Raphael**, PhD, is a Professor at the School of Health Policy and Management at York University in Toronto. Dr. Raphael is editor of *Social Determinants of Health: Canadian Perspectives* (4th ed.), *Tackling Health Inequalities: Lessons from International Experiences,* and *Immigration, Public Policy, and Health: Newcomer Experiences in Developed Nations*. He is author of *Poverty in Canada: Implications for Health and Quality of Life* (3rd ed.) and *About Canada: Health and Illness* (3rd ed.) and co-author of *The Politics of Health in the Canadian Welfare State* and co-editor of *Staying Alive: Critical Perspectives on Health, Illness and Health Care* (3rd ed.)

[2] **Toba Bryant,** PhD, is an Associate Professor in the Faculty of Health Sciences at Ontario Tech University in Oshawa, Canada. Dr. Bryant is author of *Health Policy in Canada* (3rd ed.), first editor of *Staying Alive: Critical Perspectives on Health, Illness and Health Care* (3rd ed.), co-author of *The Politics of Health in the Canadian Welfare State* and editor of the contributed volume *Handbook on the Social Determinants of Health*. She is also general editor of the academic journal, *Critical Issues: An International and Interdisciplinary Journal*. Dr. Bryant has authored numerous book chapters and journal articles on the social determinants of health, public policy change, and housing as a social determinant of health.

> reformist ilk. But we need to declare ourselves as partners with the revolutionary radicalism of those who follow in Virchow's footsteps (Labonté, 2024, 2).

Similarly, Lindsay McLaren and Elizabeth McGibbon (2025) identify the imperative of having the public health community engage in addressing the structural determinants of health**.** Like Labonté, they direct attention to the adverse health effects of capitalism: "dominant economic paradigms (capitalism)… their incompatibility with the public's health including health equity" (494). Drawing upon the conclusion of the Commission on Social Determinants of Health (2008) that "health inequities result from 'a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics,' and that closing the health equity gap will require 'tackling the inequitable distribution of power, money, and resources" McLaren and McGibbon (2025) write:

> Structural determinants of health… demand engagement with systemic power relations and their roles in creating and perpetuating inequities in the factors shaping health – including those who control dominant narratives and who benefits from economic and social inequalities (493).

It is important to note that in both commentaries, the authors do not explicitly specify what they mean by the "public health community." To our mind, the public health community includes federal and provincial public health ministries, public health agencies and units, frontline practitioners, community health advocates, university researchers, NGOs, Indigenous public health organizations, and others. It appears, however, that Labonté and McLaren and McGibbon are primarily focused on those employed by federal or provincial authorities in ministries of health, public health agencies, and university-based academic researchers whose work is funded by these same authorities.

The authors also do not explicitly define what they mean by "engagement." Engagement can mean intellectual or academic activity that results in documents and reports or academic journal articles or books that call for action to improve public health. It can also mean explicitly critical analysis of the role that governing authorities play in producing the living and working conditions that either promote or threaten public health. In this commentary we document why engagement by the public health community has been limited to the former such that explicitly critical analysis by traditional public health agencies and many academic researchers seems unlikely in the future.

We suggest that what is required to carry out critical engagement requires a broader social movement – that could involve the public health community -- to contest existing power relations that make *Health in All* – activities directed towards promoting public health by reducing health inequalities and improving the adverse living and working conditions that create these health inequalities -- almost impossible to achieve. Whether the Canadian public health community can be part of this social movement is uncertain.

The Public Health Scene in Canada

We agree with the authors that the primary determinants of health are the structures and processes of our contemporary economic system. We agree that their current problematic states are due to acceptance of neoliberal approaches to governance. We also agree that the public health community – federal and provincial ministries of health and public health agencies and units as well as researchers – should engage with these issues. Finally, we acknowledge that the public

health community has made significant though perhaps somewhat limited intellectual and theoretical contributions to understanding these issues.

The lack of public health influence upon governmental policymaking in general and the social determinants of health in particular was succinctly stated almost 20 years ago with little to suggest that much has changed:

> Canadian research and advocacy activities in the service of strengthening the Social Determinants of Health (SDOH) are so divorced from every day public policy activity, media discourse and public awareness as to metaphorically suggest that SDOH researchers and advocates exist in a Phantom Zone of irrelevance (Raphael, 2009, 193).

In support of this argument, the Canadian public health situation continues to be one that produces living and working conditions that threaten health. Political scientist Julia Lynch (2020) identifies the source of health inequalities – avoidable differences in health outcomes and access to health care -- as being governmental resistance to redistribution of income and wealth, limited spending on social programs and benefits, and unwillingness to manage the market economy. Canada performs abysmally in all of these compared to other wealthy nations (Suthakaran and Raphael, 2025).

The extent of redistribution in Canada compares very poorly to other Organization for Economic Cooperation and Development (OECD) countries as does the extent of Canada's social spending. Canada's managing of the market economy also compares poorly with significant a proportion (close to 20%) of the population earning low wages defined as constituting less than two-thirds of the average income (Organization for Economic Cooperation and Development, 2025a). This is facilitated by laws and regulations that make it difficult to organize the workplace or provide employment security; Canada ranks 34th of 35 OECD nations on employment protection for which data are available (Organization for Economic Cooperation and Development, 2022).

The extent of health inequalities in Canada is profound. Statistics Canada researchers followed 2.7 million Canadians over a 16-year period and calculated mortality rates from a wide range of diseases and injuries as a function of the person's income (Tjepkema, Wilkins, and Long, 2013). The report compares the number of deaths of the wealthiest 20% of Canadians to the other 80% of Canadians and concludes that if all were as healthy as the top 20% of Canadian income earners, there would be approximately 40,000 fewer deaths each year, with 25,000 among Canadian men and 15,000 among Canadian women.

Not surprisingly then, overall health has been declining in Canada. In 1990 Canada ranked 5th in life expectancy among 37 OECD nations, but by 2023 it was ranked 22nd, experiencing a 17-point decrease in rank (Organization for Economic Cooperation and Development, 2025b). More concerning, Canada has shown absolute declines in life expectancy for three of the past four years (Statistics Canada, 2025). In terms of infant mortality, Canada ranked 5th among OECD nations but by 2023, it ranked 30th, a decline of 25 in rank (Organization for Economic Cooperation and Development, 2025c). Despite these disturbing trends, promoting health equity is not explicitly on the public policy agenda of any federal, provincial or territorial government.

These and other details of Canadian public policies failures are readily available (Amin and Raphael, 2026; Raphael, 2025). Existing public health statements from government or public health agencies rarely identify government failures to redistribute income, spend on programs and benefits, and manage the market economy explicit and certainly do not identify Canadian government authorities as responsible for their state.

Admittedly, a few public health researchers are doing so (Borras, 2023; Bryant and Raphael, 2020; McGibbon, 2024; Muntaner and Benach, 2026; Raphael, Bryant and Amin, 2025). Nevertheless, the pleas by Labonté and McLaren and McGibbon for public health community engagement in the politics of health and the structural determinants of health seem likely to be ineffective.

Public Health Statements, Documents and Reports on Promoting Health Equity

It cannot be denied that Canada's public health community has been engaged in addressing these issues in printed documents and reports, journal articles, and books. Indeed, Canada has been seen as a leading contributor to theorizing the importance of promoting health equity through public policy action. In 1986, the landmark report *Achieving Health for* All (Epp, 1986) called for public policy action to address the lack of health equity in Canadian society. Since then, a multitude of documentation on the extent of health inequalities among Canadians has been produced by federal and provincial public health authorities, National Collaborating Centres on health funded by the federal government, and local public health units as well as academic researchers and health equity advocates (Butler-Jones, 2008; Canadian Institute for Health Information, 2015; Canadian Public Health Association, 1997, 2001; Canadian Senate, 2009; Pan-Canadian Public Health Network. 2018). Despite this, the public health scene in Canada continues to deteriorate (Amin and Raphael. 2026; Bryant and Raphael, 2020; Bryant, Raphael, Schrecker, and Labonté, 2011; Hancock, 2011; Low and Thériault, 2008; Raphael, 2025).

These findings provide strong reasons for those concerned with promoting health to offer more than exhortations to promote health equity by governing authorities. It requires explicit critiques of existing approaches to governance and the public policies that result from such governance and how they threaten health. To our mind, the perpetrators who need to be called out for these conditions are governments and the corporate and business sector whose advocacy for retrenchment of the welfare state, reducing regulation of business practices, and privatization of public institutions and agencies degrades the quality and equitable distribution of the living and working conditions that either promote or threaten public health (Raphael and Bryant, 2023).

Why the Canadian Public Health Community Cannot Critically Engage with the Politics of Health and the Structural Determinants of Health

Given these difficulties, what is the likelihood that Labonté's and McLaren and McGibbon's pleas for public health engagement will occur? If engagement is taken to mean producing statements and documents as well as research findings that describe the state of public health, depoliticized understandings of their sources, and exhortations for action, then the case could be made that the public health community has been so engaged since 1986. If it is taken to mean critical engagement with the politics of health and the role governments play in producing living and working conditions, then such pleas will continue to go unanswered. Much of this has to do with the conditions under which the public health community operates in Canadian society.

The primary barrier to the public health community critically addressing the political and structural issues that drive health is that for the most part public health employees, university researchers, and community-based advocates are employed or funded by the governing authorities whose public policies create the problematic quality and distributions of the social determinants of health, a problem identified by Cohen and Marshall (2017) in their scoping review of advocacy activity by the public health community.

These individuals cannot be expected to threaten their employment or research funding by engaging in conflictual relationships with employers and funders. These relationships of the public health community with governing authorities have proven fruitful for researchers and advocates through funding research, employment, and local initiatives to promote *Health in All*. It has also proven fruitful in contributing to theorizing the lack of health equity and means to respond. However, the stability of these relationships -- with rather little if any effect upon public policy -- has led some to suggest the existence of a *Health Inequalities Research and Advocacy Industrial Complex* in Canada that in practice perpetuates this complex and does little to achieve its goal of *Health for All* (Raphael and Bryant, 2026).

Given the problematic nature of the public health community's relationship with funders, why would these members undertake to threaten these relationships by engaging in the politics of health and the structural determinants of health? In fact, most of the members of this community are aware that governments have shown little interest in addressing the quality and distribution of the social determinants of health, suggesting that such challenges would achieve little and could come at great personal risk. As noted earlier, since the 1986 publication of *Achieving Health for All* (Epp, 1986) with it's call for the creation of "healthy public policy," public policy environments in Canada as to the quality and equitable distribution of the social determinants of health have declined (Amin and Raphael, 2026).

Making Sense of the Problematic Relationship between Governing Authorities and the Public Health Community

There is no doubt that well-meaning members of the public health community – employees, researchers and advocates – are sincere in their wish to achieve health equity. But we bemoan the ongoing willingness of this community to not challenge the source of the lack of health equity: the public policies of governments to which they are beholden. Governing authorities have proven adept at managing the problematic health equity situation by creating numerous safety valves to engage Canadian health equity researchers and advocates: funding research initiatives, establishing Collaborating Centres for Indigenous Health, Healthy Public Policy, and Determinants of Health, and producing a plethora of documents and statements on achieving *Health for All* (Government of Canada, 2025; Public Health Agency of Canada. Reports, 2026). In terms of influencing Canadian public policy, there is little if anything to show for it. For these reasons, Labonté's and McLaren and McGibbon's well-intentioned calls for action to address the politics of health will likely be added to others gathering dust on shelves.

This view is buttressed by a literature that identifies the many barriers to advocacy experienced by public servants and precariously employed academics. McGibbon and colleagues (2024) carried out focus groups with 1) public policymakers working in selected federal/ provincial/territorial government departments and initiatives; 2) policymakers who work with non-governmental and not-for-profit organizations with a role in advocating for HE (e.g., women's centers; community health centers; African Canadian, Indigenous, and Immigrant organizations); 3) academics with expertise in health and public policy (e.g., political science, nursing, economics, medicine); and 4) professional practitioners (e.g., health clinicians, leaders in health and social policy fields). They found these individuals' activities were constrained by institutional views that health equity policy action was incompatible with economic sustainability, the public was not ready for the conversation, a focus on individualism, and claims of a lack of evidence.

In another study, McGibbon and colleagues (2021) found that civil servants were working in institutions where discussion of power dynamics was disallowed. They were also constrained by neoliberal ideological understandings that focused on economic growth, investment, commercial development, and prioritized financial over human capital. Those who questioned these imperatives were likely to not be seen as "team players". Finally, Komakech (2022) identified numerous barriers to addressing health equity in the Public Health Agency of Canada and provincial and municipal governments that included avoidance of anything that smacked of politics and embeddedness in institutional structures that emphasized individual and community-based approaches to promoting health equity.

The Ways Forward

We identify two interrelated ways forward: the use of polemic and building a health equity social movement. In relation to addressing the barriers to *Health for All*, the Health Council of Canada (2005) offered this advice:

> Engage Canadians in understanding the importance of non-health care factors in determining individual and community health. Use strong language. Health disparities are the number one health problem in the country and health care alone is powerless to overcome them. The health disparity between groups in Canadian society and the impact of the gap must be reported and highlighted. This is a difficult message to get across in the current environment where the public is pre-occupied with funding for health care. But it needs to be done (9).

The idea of using strong language, i.e., polemic, was explored by Raphael and colleagues (2022) who suggested promoting *Health for All* required "using high valence terms such as structural violence, social death, and social murder, which make explicit the adverse outcomes of health-threatening public policy to force government action (130-131). The use of such terms is increasing in both the academic and popular literature (Medvedyuk, Govender, & Raphael, 2021; Nicoll, 2022). It needs to be heard more often but having members of the public health community do so would threaten their government funding and employment.

The second way forward is building a social movement (Raphael and Bryant, 2025). Michael Marmot (2017) called for a social movement to promote health but his concept limits involvement to experts, professionals, and public health authorities. Flynn (2011) states: "The term social movement refers to a deliberate, voluntary effort to organize individuals to act in concert to achieve enough group influence to make or block changes" (26-27). Social movements arise because a situation is perceived as being unacceptable and governing authorities are unwilling to address it.

The social movements literature argues that challenging problematic societal circumstances – and clearly the public policy environment regarding health equity in Canada conforms to this situation – requires the following (della Porta and Diani, 2020).

- actors being engaged in collective action in conflict with clearly identified opponents
- through the formation of dense, informal networks
- with which they share a distinct collective identity.

A public health social movement would differ from traditional public health activities. It would develop in opposition to these processes and entail explicit resistance to established conditions through a variety of means that may include public protests, petitions, and other outside-the-system

activities. Public health itself could not lead such a movement but could act in concert with it. The current situation in Canada – described by Labonté and McLaren and McGibbon – contains the seeds of a broader social movement.

Of these three required components of a social movement, the first is the most problematic for the public health community to act upon. For us, and apparently, Labonté, McLaren, and McGibbon, the identified opponents to *Health for All* are 1) governing authorities who, despite almost 40 years of research and equity since publication of *Achieving Health for All*, show no inclination to redistribute income and wealth, increase social spending and manage the market economy; 2) the corporate and business sector who clearly benefit from the present public policy environment and have undue influence upon governing authorities, and 3) the current form of neoliberal capitalism which Labonté, McLaren and McGibbon identify as blocking *Health for All*. For reasons mentioned earlier, the public health community cannot bite the hand that feeds it.

Secondly, public health researchers and practitioners are not part of dense informal networks. Efforts to form such networks such as the "Upstream" initiative of Ryan Meili, now managed by the Canadian Centre for Policy Alternatives (2025) has failed as Upstream has had limited success in meeting its goals of informing the public about health equity issues and is now moribund. Its last blog entry is dated December 4, 2023. Third, mainstream media indifference to broader health factors occurs because they are themselves constrained by political and economic forces, including ownership structures and a media logic that focuses on concrete presentations of material that is already consistent with audience understanding of the nature of health and its determinants of health (Medvedyuk, Govender, and Raphael, (2023). Fourth, public and media conflating health with health care also limits the ability of the public to understand the politics and structural determinants of health (Bambra, Fox, and Scott-Samuel, 2005). Hence the lack of a common public health identity for achieving *Health for All.*

Labonté and McLaren and McGibbon do not mention a social movement approach or how the public health community could be part of it. For the reasons presented above, the public health community cannot itself become a social movement, but it can work with others to establish one. In fact, the statements and research findings that have emanated from the community health sector community certainly underscore the reasons why such a movement is necessary. Such a social movement would draw together researchers and advocates, but more importantly, the public, who would recognize that the current public policy environment in regard to social determinants of health such as income and wealth distribution, employment security, working conditions, food and housing security, among others are unacceptable and demand action by governing authorities.

To achieve this goal, we are engaging with the social movement literature to systematically review the structures, processes, and successes and failures of a variety of social movements – Social Medicine, Environmental, Social Justice, Labour, Political, and Anti-Globalization – to identify lessons and insights that may assist in the development of a health equity social movement in Canada. To this end, we are preparing a volume for *Policy Press* that identifies what needs to be done to create a *Health in All* social movement.

In the volume we draw upon the social movements literature to identify (1) the importance of promoting health equity; (2) how a social movement could promote health equity; (3) why health equity activities fail to meet the requirements of a social movement as traditionally defined; (4) consider lessons learned from other social movements across the globe; and (5) identify means of building a health equity social movement in Canada and elsewhere.

Conclusion

We applaud the call for action on the part of Labonté, McLaren and McGibbon for public health engagement with the politics of health and the structural determinants of health. We recognize that the Canadian public health community has contributed to describing the importance of promoting health equity. To date, however, these contributions have been depoliticized and unwilling to identify how specific aspects of economic and political systems within which public health is embedded need to be radically reformed or transformed.

Cohen and Marshall (2017) made a similar argument to ours: "In order to address the structural underpinnings of health inequities, public health advocacy must catalyse multi-sectoral efforts that implicate the state and corporations in the production of health inequities, and rally state involvement to redress these injustices" (322). We are not confident however, that Canadian governing authorities in the throes of neoliberalism and under corporate influence will voluntarily act upon these issues. Hence, the need for a health equity social movement that will literally force their hand.

Therefore, we are not confident that Labonté's and McLaren and McGibbon's call for engagement in the political and structural determinants of health will by itself move us forward. What is necessary is not only "the willingness to think and act critically… for uncovering the health damaging effects of particular social structures, in their political and historical context; and challenging those structures" (McLaren and McGibbon, 2025, 494). It also requires a willingness to recognize that the same structures and processes that make *Health for All* difficult to achieve – neoliberal capitalism or capitalism itself – and the public health community's embeddedness in these structures – make public health involvement in addressing structural issues difficult if not impossible. We hope that drawing lessons from a wide variety of social movements can identify the means by which public health could become a true social movement that would implement the activities required to achieve *Health for All*.

References

Amin, R. and Raphael, D. (2026). Late-stage capitalism and the Canadian polycrisis in living and working conditions: Implications for health and means of responding. *International Journal of Social Determinants of Health and Health Services, 56, (2)*, 161-172. https://journals.sagepub.com/doi/10.1177/27551938251411280

Bambra, C., Fox, D., & Scott-Samuel, A. (2005). Towards a politics of health. *Health Promotion International, 20*(2), 187-193. https://academic.oup.com/heapro/article/20/2/187/827479

Borras, A. M. (2023). The challenge of exposing and ending health inequalities through social and policy change: Canadian experiences. *International Journal of Social Determinants of Health and Health Services, 53*(2), 130-145. https://journals.sagepub.com/doi/full/10.1177/27551938221148376

Bryant, T., Raphael, D., Schrecker, T., and Labonté, R. (2011). Canada: A land of missed opportunity for addressing the social determinants of health. *Health Policy*, 101(1), 44-58. https://www.sciencedirect.com/science/article/abs/pii/S0168851010002563

Bryant, T. and Raphael D. (2020) *The politics of health in the Canadian welfare state.* Canadian Scholars' Press. https://canadianscholars.ca/book/the-politics-of-health-in-the-canadian-welfare-state/

Butler-Jones, D. (2008). *The Chief Public Health Officer's report on the state of public health.* Public Health Agency of Canada. https://www.phac-aspc.gc.ca/cphorsphc-respcacsp/2008/fr-rc/pdf/CPHO-Report-e.pdf

Canadian Centre for Policy Alternatives (2023). Think Upstream. https://www.policyalternatives.ca/news-research/think-upstream-project/

Canadian Institute for Health Information. (2015). *Trends in income-related health inequalities in Canada.* https://www.cihi.ca/en/trends-in-income-related-health-inequalities-in-canada

Canadian Public Health Association (1997). *Health impacts of social and economic conditions: Implications for public policy.* https://www.cpha.ca/sites/default/files/assets/policy/health_e.pdf

Canadian Public Health Association (2001). *Creating conditions for health.* https://www.cpha.ca/sites/default/files/assets/policy/conditions_e.pdf

Canadian Senate (2009). *Fifth report: a healthy, productive Canada: A determinant of health approach*. https://sencanada.ca/content/sen/committee/402/popu/rep/rephealth1jun09-e.pdf

Commission on Social Determinants of Health. (2008). *Closing the gap in a generation: health equity through action on the social determinants of health: Final report of the commission on social determinants of health.* World Health Organization. https://www.who.int/publications/i/item/WHO-IER-CSDH-08.1

della Porta, D., and Diani, M. (2020). *Social movements: An introduction* (3rd ed). Wiley-Blackwell. https://www.wiley.com/en-us/shop/general-sociology/social-movements-an-introduction-3rd-edition-p-9781119167655

Epp J. (1986). Achieving health for all: A framework for health promotion. *Health Promotion International,* 1(4), 419-428. https://academic.oup.com/heapro/article/1/4/419/933933

Flynn, S. (2011). Types of social movements. In *Theories of social movements* (pp. 26-36). Salem Press. https://www.scribd.com/document/89474320/Theories-of-Social-Movements-pdf

Government of Canada (2025). National Collaborating Centres for Public Health. jhttps://www.canada.ca/en/public-health/services/public-health-practice/national-collaborating-centres-public-health.html

Hancock T. (2011). Health promotion in Canada: 25 years of unfulfilled promise. *Health Promotion International*, 1;26 (suppl_2), ii263-267. https://academic.oup.com/heapro/article/26/suppl_2/ii263/579220

Health Council of Canada. (2005). *Health care renewal in Canada: Accelerating change*. https://publications.gc.ca/collections/collection_2012/ccs-hcc/H174-37-2005-eng.pdf

Komakech, M. D. C. (2022). *From the standpoint of policymakers: An institutional ethnography inquiry into the policymaking process to address health equity and social determinants of health in Canada.* York University PhD dissertation. https://yorkspace.library.yorku.ca/items/c06d430c-1901-484c-8a8b-c8eb093789cd

Labonté, R. (2024). Public health can no longer fence-sit politically. *Canadian Journal of Public Health, 115*(5), 701-704. https://link.springer.com/article/10.17269/s41997-024-00941-2

Low, J., and Thériault, L. (2008). Health promotion policy in Canada: Lessons forgotten, lessons still to learn. *Health Promotion International, 23*(2), 200-206. https://academic.oup.com/heapro/article/23/2/200/713563

Lynch, J. (2020). *Regimes of inequality: The political economy of health and wealth.* Cambridge University Press. https://www.cambridge.org/core/books/regimes-of-inequality/AC06054B4B2C94638F3ECA02430B9D60

Marmot, M. (2017). Commentary. Social determinants and the health gap: Creating a social movement. *International Journal of Epidemiology, 46*(4), 1335-1339. https://academic.oup.com/ije/article/46/4/1335/4102091

McGibbon, E. (2024). Structural determinants of health: Towards a political economy of health perspective for nursing. *Witness: The Canadian Journal of Critical Nursing Discourse, 6*(1), 1-7. https://witness.journals.yorku.ca/index.php/default/issue/view/11

McGibbon, E., Fierlbeck, K., and Ajadi, T. (2021). Health inequity and institutional ethnography: Mapping the problem of policy change. *Witness: The Canadian Journal of Critical Nursing Discourse, 3(*2), 64-80. https://witness.journals.yorku.ca/index.php/default/article/view/117

McGibbon, E., Fierlbeck, K., and Ajadi, T. (2024). Institutional ethnography as critical policy analysis: Health equity discourses in Canadian public policy. *Critical Studies: An International and Interdisciplinary Journal,* 18(1). https://ojs.scholarsportal.info/ontariotechu/index.php/cs/article/view/162

McLaren, L., and McGibbon, E. (2025). What do we mean by structural determinants of health, why is it important, and are public health communities ready to engage? *Canadian Journal of Public Health,* 1-5. https://link.springer.com/article/10.17269/s41997-025-01122-5

Medvedyuk, S., Govender, P., & Raphael, D. (2021). The reemergence of Engels' concept of social murder in response to growing social and health inequalities. *Social Science & Medicine, 289,* 114377. https://www.sciencedirect.com/science/article/abs/pii/S0277953621007097

Medvedyuk, S., Govender, P., & Raphael, D. (2023). Communicating Friedrich Engels's return to Manchester: Arts and cultural event, history lesson, or call to action? *Human Geography, 16*(1), 31-44. https://journals.sagepub.com/doi/10.1177/19427786221120659

Muntaner, C., & Benach, J. (2026). Power, precariousness, and health equity: The contested terrain of population health. *International Journal of Social Determinants of Health and Health Services, 56*(2), 147-149. https://journals.sagepub.com/doi/10.1177/27551938261421775

Nicoll, D. (2022). Canada needs to measure its wealth in terms of social murder, not GDP. *Rabble,* July 8. https://rabble.ca/health/canada-needs-to-measure-its-wealth-in-terms-of-social-murder-not-gdp/

Organization for Economic Cooperation and Development (2022). Strictness of employment protection. https://data explorer.oecd.org/

Organization for Economic Cooperation and Development (2025a). Incidence of low and high pay. https://www.oecd.org/en/data/indicators/incidence-of-low-and-high-pay.html

Organization for Economic Cooperation and Development (2025b). Life expectancy. https://www.oecd.org/en/data/indicators/life-expectancy-at-birth.html

Organization for Economic Cooperation and Development (2025c). Infant mortality, https://www.oecd.org/en/data/indicators/infant-mortality-rates.html

Pan-Canadian Public Health Network (2018). *Key health inequalities in Canada: A national portrait*. Public Health Agency of Canada. https://www.canada.ca/content/dam/phac-aspc/documents/services/publications/science-research/key-health-inequalities-canada-national-portrait-executive-summary/hir-full-report-eng.pdf

Public Health Agency of Canada. Reports (2026). https://www.canada.ca/en/public-health/services/reports-publications.html

Raphael, D. and Bryant, T. (2026). Mapping the health inequalities research and advocacy industrial complex in Canada. Paper under review.

Raphael, D., Bryant, T. and Amin, R. (2025). Promoting health equity in an era of growing contradictions between capital accumulation and social reproduction in capitalist economies. *Community Health Equity Research and Policy.* https://doi.org/10.1177/2752535X251370927

Raphael, D., Bryant, T., Govender, P., Medvedyuk, S., and Mendly-Zambo, Z. (2022). Desperately seeking reductions in health inequalities in Canada: Polemics and anger mobilization as the way forward? *Sociology of Health and Illness*. 44(1):130-146. https://onlinelibrary.wiley.com/doi/full/10.1111/1467-9566.13399

Raphael, D., Bryant, T. (2023). Socialism as the way forward: Updating a discourse analysis of the social determinants of health. *Critical Public Health, 8*;33(4), 387-394. https://www.tandfonline.com/doi/full/10.1080/09581596.2023.2178387

Raphael, D. and Bryant, T. (2025). Why promoting health equity in Canada requires a social movement. *Community Health Equity Research and Policy. https://doi.org/10.1177/2752535X261427*

Raphael D. (2025). *Social Determinants of Health: Canadian Perspectives* (4th ed.) Canadian Scholars' Press. https://canadianscholars.ca/book/social-determinants-of-health-fourth-edition/

Raphael, D. (2009). Escaping from the Phantom Zone: Social determinants of health, public health units and public policy in Canada. *Health Promotion International, 24*(2), 193-198. https://academic.oup.com/heapro/article/24/2/193/567418

Statistics Canada (2025). *Key findings from the Health of Canadians report, 2024.* https://www150.statcan.gc.ca/n1/daily-quotidien/250305/dq250305a-eng.htm

Suthakaran, K., and Raphael, D. (2025). Canada and the three public policy taboos: Promoting health equity in difficult times. *Critical Studies: An International and Interdisciplinary* Journal, 19(1). https://ojs.scholarsportal.info/ontariotechu/index.php/cs/article/view/373

Tjepkema, M., Wilkins, R., & Long, A. (2013). *Cause-specific mortality by income adequacy in Canada: a 16-year follow-up study.* Statistics Canada. https://www150.statcan.gc.ca/n1/en/pub/82-003-x/2013007/article/11852-eng.pdf?st=GcBnzf95