Barriers to employment-related healthy public policy in Canada

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SUMMARY

The Ottawa Charter for Health Promotion calls for building healthy public policy, that is for ‘[putting] health on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health’. The objective of this study was to assess the past and potential future influence of information about the health consequences of unemployment and job insecurity on policy making and to identify the barriers to the use of such information in policy making. We conducted telephone interviews with 38 policy makers in the health and employment sectors of all three levels of Canadian government, as well as the executive directors of 10 Canadian non-governmental organizations that are active on employment issues. The interviews included both numerical ratings of the influence of this information and semi-structured questions about how this information could be used in policy making. Using an interpretive approach grounded in the political science literature, we identified barriers to using this information in their responses to these questions. Respondents rated the potential future influence of this information (mean 4.2 and median 5 on a seven-point Likert scale) higher than its past influence (mean 3.5 and median 3 on a seven-point Likert scale). Barriers related to the information itself or more commonly to the values of those who could respond to the information (i.e. idea-related barriers) were cited more frequently than either barriers related to how decisions are made (i.e. institution-related barriers) or barriers related to who would win and who would lose if the information were acted upon (i.e. interest-related barriers). We concluded that to build employment-related healthy public policy, these barriers would have to be overcome. Policy makers in health departments could, for example, frame information about health consequences in language that fits more easily with the values of other departments and advocate for institutional innovations that establish cross-departmental or cross-governmental accountability for health.

Key words: employment; healthy public policy; job insecurity; policy makers

INTRODUCTION

The Ottawa Charter for Health Promotion calls for building healthy public policy, that is for ‘[putting] health on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health’ [World Health Organization (WHO), 1986]. Policies that govern or influence employment and job security provide a good test case for building healthy public policy [e.g. (WHO, 1988; McBeath, 1991; Canadian Public Health Association, 1996; WHO Regional Office for Europe, 1999)]. Health is rarely on the agenda of policy makers in this area. Policy making can occur in several sectors (e.g. departments of labour, social services, education and training) and at all levels of government (federal, provincial or state, and municipal). And the decisions taken in this policy
domain can have important health consequences (Dooley et al., 1996).

In the charter’s discussion of how to achieve an objective of building healthy public policy, it argues that healthy public policy ‘requires the identification of obstacles to the adoption of healthy public policies in non-health sectors, and ways of removing them’ (WHO, 1986). Many health promotion researchers have written about barriers to healthy public policy. Some have focussed on approaches to action in general [see, e.g. (Milio, 1985a; Milio, 1991; Rutten, 1995)] or in a specific field [see, e.g. Anderson on addiction (Anderson, 1994) and Milio on food and nutrition (Milio, 1998)]. Others have provided appraisals of action in a specific field [see, e.g. Milio on tobacco (Milio, 1985b); Anderson on addiction (Anderson, 1994); Nutbeam on youth (Nutbeam, 1997); and Goumans and Springett on healthy cities (Goumans and Springett, 1997)]. More recently, some have conducted empirical research on barriers to action in general [see, e.g. (de Leeuw and Polman, 1995)] and on knowledge and attitude barriers to action in a specific field [see, e.g. (de Guia et al., 1998)]. No researchers have examined the full range of potential barriers to the development of healthy public policies in a specific field.

In this paper we assess empirically the past and potential future influence of information about the health consequences of unemployment and job insecurity on policy making, and identify the barriers to the use of such information in the development of public policy. We focus on unemployment and job insecurity because the research literature about the health consequences of these employment-related experiences is well developed. Our methods involve both a deductive/quantitative element (with numerical ratings of influence examined using descriptive statistics) and an inductive/qualitative element (with responses to semi-structured questions examined using an interpretive approach grounded in the political science literature). We draw from our empirical findings some implications for building healthy public policy in the area of unemployment and job insecurity, as well as for building healthy public policy in other policy domains.

METHODS

We conducted telephone interviews (which included both structured and semi-structured components) with a purposive sample of Canadian policy makers who are active on health or employment issues and with a purposive sample of the executive directors (or senior staff members designated by the executive directors) of Canadian non-governmental organizations (NGOs) that are active on employment issues. For policy makers, we identified participants so as to provide a range of views across levels of government (federal, provincial and municipal) and across departments within a level of government (health and one or more of employment, education and training, and income assistance). Ontario and British Columbia, two of Canada’s three largest provinces, were chosen as illustrative examples at the provincial level and the City of Toronto, Canada’s largest city, was chosen as an illustrative example at the municipal level. For executive directors of NGOs, we identified participants so as to provide a range of views across roles in the policy process (national organizations and local organizations in the same municipality —Toronto—from which municipal policy makers were chosen).

We interviewed more policy makers in the federal government than in other levels of government because they control a disproportionate share of the policy instruments for employment issues compared with these other levels and we wanted to ensure that we obtained a fully representative range of input from them. This control arises either because the federal government has primary constitutional authority over a labour-market policy instrument (e.g. unemployment insurance) or, in circumstances where it shares constitutional authority with provincial governments, because the federal government is the dominant funder of the related programmes (e.g. training programmes) (Tuohy, 1992). Within a government department, we identified senior policy staff using both organizational charts and the recommendations of key informants. Eligible policy makers and executive directors were provided with an information package containing a covering letter, a one-page description of the study, a two-page interview guide, and a consent form. Individuals who declined to participate were asked to provide a reason and to recommend someone else in their department who could be contacted.

The telephone interviews included numerical ratings of the past and potential future influence of information on the health consequences of unemployment and semi-structured questions about
how this information could be used in policy making. The two numerical ratings of influence bracketed the interview: the question about past influence was asked first (with the seven-point Likert scale ratings anchored by ‘no influence’ and ‘significant influence’) and the question about potential future influence (with the seven-point Likert scale ratings anchored by ‘not likely’ and ‘very likely’) was asked last. The questions about how this information could be used in particular initiatives were preceded by non-technical summaries of research findings about particular aspects of the relationship between unemployment and health or job insecurity and health. These summaries and related questions are provided in an appendix. Two additional open-ended questions focussed on the implementation of any initiatives: one question asked about federal cross-departmental initiatives and the other asked about partnerships between the federal government and either other levels of government or NGOs.

We examined the numerical ratings of influence using descriptive statistics and the responses to semi-structured questions using an interpretive approach grounded in the political science literature. The first-level coding of barriers was conducted using an organizing framework which distinguishes among ideas, interests and institutions [e.g. (Garrett and Weingast, 1993)]. Thus barriers were grouped into those related to the information itself or the values of those who could respond to the information (i.e. idea-related barriers), those related to who would win and who would lose if the information were acted upon (i.e. interest-related barriers), and those related to how decisions are made (i.e. institution-related barriers). The second-level coding was conducted more inductively. We provide representative quotations that best illustrate frequently cited barriers.

We examined these ratings and responses to questions for the entire sample and for each of three respondent categories. The respondent categories are as follows: health policy makers (i.e. policy makers in the department dealing with health issues at any of three levels of Canadian government), employment policy makers (i.e. policy makers in departments dealing with employment, education and training, and income assistance at any of three levels of Canadian government), and executive directors of Canadian NGOs that are active on employment issues.

RESULTS

We interviewed 38 policy makers and 10 NGO executive directors. These respondents were balanced between those inside the federal government and those outside of it (n = 24 for each category), and between health policy makers and employment policy makers (n = 19 for each category), as well as roughly balanced between non-federal governments (n = 14) and NGOs (n = 10). The response rate across all eligible respondents was 42% and was higher among health policy makers (especially at the national level) than among employment policy makers or NGO executive directors. Response rates are provided in Table 1.

The most commonly cited reasons for declining to participate were that the respondent felt that he or she was not well enough informed (n = 17), or that he or she had delegated the task of being interviewed to a subordinate or felt

<table>
<thead>
<tr>
<th>Table 1: Response rates by respondent category</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Respondent category</strong></td>
</tr>
<tr>
<td>Total</td>
</tr>
<tr>
<td>Health policy makers</td>
</tr>
<tr>
<td>Federal</td>
</tr>
<tr>
<td>Provincial</td>
</tr>
<tr>
<td>Municipal</td>
</tr>
<tr>
<td>Employment policy makers</td>
</tr>
<tr>
<td>Federal</td>
</tr>
<tr>
<td>Provincial</td>
</tr>
<tr>
<td>Municipal</td>
</tr>
<tr>
<td>NGO executive directors</td>
</tr>
<tr>
<td>National</td>
</tr>
<tr>
<td>Local</td>
</tr>
</tbody>
</table>

*Excludes individuals on sabbatical or retired.
that he or she would repeat the responses of a superior \((n = 17)\). An approximately equal number of eligible respondents didn’t respond to contact attempts \((n = 16)\). A small number of eligible respondents explicitly stated that the information did not apply to them or refused to be interviewed, either directly or indirectly by citing ‘too busy’ or not making time for the interview during the study period. The frequency of each reason given for declining to participate is provided in Table 2.

The ratings for the influence of information about the health consequences of unemployment tended to be in the mid-range on the seven-point Likert scales, and they varied across both respondent categories and time period. Employment policy makers gave the lowest ratings for both past and potential future influence of this information. NGO executive directors gave the highest ratings for past influence and health policy makers gave the highest ratings for potential future influence. Policy makers, unlike the executive directors of NGOs, gave higher ratings to the potential future influence of information about the health consequences of unemployment than to the past influence of such information. Mean and median ratings of past and potential future influence are provided in Table 3.

Can we clearly situate the barriers to the past or potential future influence of this information in the information itself, in the values of those who could respond to the information, in how decisions are made, or in who would win or who would lose if the information were acted upon? The answer carries with it important implications for building healthy public policy. If all of the barriers relate in some way to how decisions are made, for example, then the success of efforts to build healthy public policy will hinge on our ability to bring about significant change to our decision-making structures. On the other hand, if the barriers all involve the information itself, then success will hinge on improving the relevance and availability of information.

### Table 2: Reasons for declining to participate by respondent category

<table>
<thead>
<tr>
<th>Respondent category ((n))</th>
<th>Not well informed (n)</th>
<th>Information did not apply (n)</th>
<th>Delegated to subordinate or felt would repeat superior (n)</th>
<th>Refused, too busy or not able to schedule (n)</th>
<th>Never responded to contact attempts (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total ((65))</td>
<td>17</td>
<td>6</td>
<td>17</td>
<td>9</td>
<td>16</td>
</tr>
<tr>
<td>Health policy makers ((16))</td>
<td>6</td>
<td>5</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Federal ((8))**</td>
<td>5</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Provincial ((6))</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Municipal ((2))</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Employment policy makers ((30))</td>
<td>10</td>
<td>0</td>
<td>10</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Federal ((18))**</td>
<td>9</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Provincial ((8))</td>
<td>1</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Municipal ((4))</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>NGO executive directors ((19))</td>
<td>1</td>
<td>1</td>
<td>5</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>National ((8))</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Local ((11))</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>5</td>
</tr>
</tbody>
</table>

**Excludes individuals on sabbatical or retired.

### Table 3: Past and potential future influence of information about the health consequences of unemployment by respondent category

<table>
<thead>
<tr>
<th>Respondent category</th>
<th>(n)</th>
<th>Mean (median) rating of past influence</th>
<th>Mean (median) rating of potential future influence</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>48</td>
<td>3.5 (3)</td>
<td>4.2 (5)</td>
</tr>
<tr>
<td>Health policy makers</td>
<td>19</td>
<td>3.2 (3)</td>
<td>4.6 (5)</td>
</tr>
<tr>
<td>Employment policy makers</td>
<td>19</td>
<td>2.9 (2)</td>
<td>3.8 (4)</td>
</tr>
<tr>
<td>NGO executive directors</td>
<td>10</td>
<td>5.2 (6)</td>
<td>4.1 (4)</td>
</tr>
</tbody>
</table>
We found that idea-related barriers were cited more than twice as often as either institutional or interest-related barriers. However, if idea-related barriers are subdivided into those that relate to the information itself and how it is made available to users (i.e. information-related barriers) and those that relate to the values of those who could respond to the information (i.e. values-related barriers), then the citations of barriers were split approximately equally across these four types (i.e. across information-, values-, institution- and interest-related barriers). The frequency with which each type of barrier is cited is provided in Table 4.

### Table 4: Barriers to the use of information about the health consequences of unemployment and job insecurity on health by respondent category

<table>
<thead>
<tr>
<th>Type of barrier</th>
<th>Health policy maker</th>
<th>Employment policy maker</th>
<th>NGO executive director</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Idea-related barriers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Against current department philosophies, priorities, strategies or realities</td>
<td>15</td>
<td>13</td>
<td>4</td>
<td>32</td>
</tr>
<tr>
<td>Weak evidence</td>
<td>7</td>
<td>7</td>
<td>3</td>
<td>17</td>
</tr>
<tr>
<td>General</td>
<td>3</td>
<td>3</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Regional variations</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Information not getting to the right people in the right way</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Institution-related barriers</td>
<td>7</td>
<td>7</td>
<td>1</td>
<td>15</td>
</tr>
<tr>
<td>Jurisdictional authority issues</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>between departments</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>between levels of government</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Government partnerships</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Lack of accountability for cross-departmental or cross-government issues</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Interest-related barriers</td>
<td>5</td>
<td>5</td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td>Against stakeholders’ interests, which support the status quo</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Against public and media opinion, both of which support the status quo</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Against departmental interests, which support the status quo</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Total barriers</td>
<td>27</td>
<td>25</td>
<td>7</td>
<td>59</td>
</tr>
</tbody>
</table>

We found that idea-related barriers were cited more than twice as often as either institutional or interest-related barriers. However, if idea-related barriers are subdivided into those that relate to the information itself and how it is made available to users (i.e. information-related barriers) and those that relate to the values of those who could respond to the information (i.e. values-related barriers), then the citations of barriers were split approximately equally across these four types (i.e. across information-, values-, institution- and interest-related barriers). The frequency with which each type of barrier is cited is provided in Table 4.

### Idea-related barriers

Respondents cited conflicts between the policy implications of the information and current department philosophies, priorities or strategies (i.e. values-related barriers) more frequently than any other barrier to the use of information about the health consequences of unemployment and job insecurity. As an example of the policy implications of the information (hereafter simply referred to as ‘the information’) contravening current department philosophies, one respondent argued:

> The current political climate will only move on economic impacts associated with unemployment statistics or theories, rather than respond to the obvious social impacts which everyone can see.

Respondents felt that the information could be ‘repackaged’, however, to fit more easily within such an ‘economic development’ philosophy. One of these respondents went on to say:

> If you could demonstrate that a wounded workforce was incapable of making the transition into new employment, and that this affected competitiveness [as well as] social services, [unemployment insurance] and other systems, people would listen.

One respondent cautioned against ‘defining health in pure economic terms’.

A number of respondents suggested that this information contravenes current department priorities and strategies (as distinct from department philosophies, which are more general and implicit). A federal employment policy maker
cited economic restructuring as their overall priority:

Most studies of this nature [i.e. those listed in the appendix] are not paid attention to, or receive little attention, due to the fact that they contravene the trajectory of the overall restructuring agenda.

Questions specific to job insecurity and regional variations in the health consequences of unemployment elicited additional examples of how this information contravenes department priorities: a federal employment policy maker felt that the department’s priority was addressing unemployment, not job insecurity, and another respondent from the same department felt that the priority was addressing unemployment in the hardest hit areas (not in areas with low unemployment rates where the research literature suggests the health consequences may be more significant).

Weak evidence, an information-related barrier, was much less commonly cited than values-related barriers. One health policy maker expressed concern about the validity of the information in general, stating:

We need concrete evidence and guarantees of validity in order to move towards adding something to a priority list.

Other respondents felt that the wrong type of data was available:

The extent to which you can demonstrate that this information will work will help increase awareness and the potential for increased initiatives.

That is, information about associations is helpful, but information about the effectiveness of interventions is needed before action could be taken. Several respondents questioned the finding about substance abuse, arguing (with anecdotal, not empirical support) that Canadians smoked, drank alcohol and abused drugs more after job loss. Another respondent questioned the finding about how the health consequences of unemployment vary according to the local unemployment rate.

Another information-related barrier—the information not getting to the right people in the right way—was cited by five respondents. One respondent commented that:

Viability [of any initiatives] is weak considering the low critical mass of informed policy makers.

A municipal employment policy maker highlighted the importance of approaching the transfer of this information differently:

Information of this nature never really reaches the right people and when it does it’s either presented in an unreadable manner, or it filters through the media or an advocacy source, and who has time for that?

Another respondent offered a potential solution:

[The health department] should really move in the same vein that [the environment department] has done, that is by imparting evidence systematically to key departments.

**Institution-related barriers**

While barriers related to the information or to the values of those who could respond to the information convey part of the story, respondents suggested several ways in which the manner in which decisions are made could act as barriers to the use of this information. One type of institution-related barrier involves the established mandates and budgets of departments within the same level of government. One department may be perceived to have the mandate and budget to address employment, another to address health. A barrier related to jurisdictional authority arises when these perceptions get in the way of either department addressing employment and health together. One respondent observed:

Departmental siloing ... is seriously preventing [our] ability to create effective dialogue.

Respondents offered many potential solutions: a health impact questionnaire to be used in departments other than health, a health officer who would advocate for a health perspective in other government departments, or a formal inter-departmental initiative. Another respondent felt that:

An information exchange network between departments ... is going to need some time to develop trust and security, which is a shame.

A second type of institutional barrier involves jurisdictional authority between levels of government. An employment policy maker made the following comment:

There is certainly room for developing partnerships that would impact [sic] on the issues you have outlined,
however, there are real jurisdictional issues, mistrust and deceit between [us and] our counterparts [at other levels of government].

Federal/provincial jurisdictional authority issues were specifically raised by a provincial policy maker in the context of a discussion of how the biological responses to unemployment appear to be particularly concentrated in the anticipatory phase of unemployment, that is after notification of pending job loss and before actual job loss occurs. The policy maker had been frustrated by federal policy makers’ unwillingness to ‘use [unemployment] insurance funds in trying [to] buffer the anticipatory phase’.

Existing government partnerships and a lack of accountability for addressing issues that cross a departmental or governmental boundary were also cited as an institution-related barrier to the use of this information. Commenting on existing partnership agreements between federal departments, one federal employment policy maker said that:

Each [department] has had a priority list for some time and has not shown that they will deviate from specific partnership agreements.

Another policy maker in the same department raised the issue that:

Some partnerships preclude … partnerships [with other levels of government].

Providing yet another perspective, a federal health policy maker cited trade agreements between Canada and other countries as a barrier to interventions related to unemployment or job insecurity. Discussing the lack of accountability for cross-departmental or cross-jurisdictional issues such as the health consequences of unemployment and job insecurity, a policy maker commented:

Here there are competing interests and this information will likely fall between the cracks.

**Interest-related barriers**

The final category of barriers involves the interests of stakeholders, the interests of bureaucrats, and public and media opinion. The first of these interest-related barriers may arise when the action suggested by the information is against the interests of stakeholders that support the status quo. Some respondents were concerned about international bond and debt holders:

The [federal] government … is hesitant to bring down the number of unemployed because it will affect the level of interest rates, which will ultimately upset the bond markets, who hold the majority of our foreign debt. It is kind of like the current smoking dilemma: do we introduce new legislation that will discourage smoking when it brings in such a high volume of tax revenue and spin-offs.

Other respondents cited the interests of employers as a barrier. These employers may be attached to the savings from the downsizing of their own businesses or of governments or ‘see job insecurity as viable [sic] to competitiveness, and productivity, because employees are under pressure to perform and know that their job is in demand’. An NGO executive director commented that:

The agencies we fund … feel that education, training and employment programmes are a traditional government jurisdiction, and don’t want [our organization’s] money to be spent in these areas.

The action suggested by this information may also be against bureaucrats’ interests or their perception of public and media opinion. An NGO executive director made the following observation about departments’ interests:

There is no certainty that this information will not drain funding from within a ministry or another ministry’s programmes: they are protective and territorial.

An employment policy maker echoed this argument:

I think there is potential for people to work together … The problem is everyone wants to drive the boat, and there is only room for so many aboard.

Several respondents also felt that public and media opinion supported the status quo. One respondent argued that:

The public has supported the downsizing within government, and the private sector continues to rely on the savings these types of measure will inevitably produce.

Some felt that the solution lay in involving the media, and specifically a credible media
commentator. An NGO executive director argued that:

The political future could be changed if this information were imparted to the media … This information is politically volatile …

DISCUSSION

Building employment-related healthy public policy presents a formidable challenge. The ratings of the past influence of information about the health consequences of unemployment were located roughly half-way between ‘no influence’ and ‘significant influence’. The ratings of potential future influence, while generally higher than the ratings of past influence, were roughly half-way between ‘not likely’ and ‘very likely’. Perhaps of more concern, employment policy makers gave the lowest ratings of the three participant categories to both past and potential future influence. Yet employment policy makers control a disproportionate share of the policy levers for employment issues, hence the need to identify and address barriers to employment-related healthy public policy.

The success of any given effort to build employment-related healthy public policy does not appear to depend solely on who would win and who would lose (and the political influence of these potential winners and losers) if information about health consequences were acted upon. From the perspective of policy makers, some groups who matter to them may lose if information about the health consequences of unemployment and job insecurity were acted upon; others may win. And not much can be done about who stands to win and lose, although compensation can of course be offered through action in other areas. Nevertheless, policy makers do appear to go beyond simple interest-based calculations in deciding whether to act on such information.

If citation frequency is any indication, the success of efforts to build employment-related healthy public policy [as was predicted by Rutten (Rutten, 1995)] depends far more on how information about health consequences coincides with or flies in the face of the values of those who could respond to the information. Several health policy makers offered the same suggestion about how they would seek to overcome this barrier: reframe information about health consequences in language that fits more easily with the values of other departments. This will be possible only in circumstances in which the policy implications of the information add to or complement an existing policy focus, like the Canadian federal government’s current focus on social cohesion (Department of Canadian Heritage, 1997). Policy making is not only about conflict resolution, however; it is also about learning (Heclo, 1974). The values of the policy makers and NGOs that focus on employment issues may shift over time as they learn more about health consequences—a form of research-related learning (Weiss, 1979; Lavis, 1997)—even without such reframing.

While respondents cited values-related barriers much more frequently than information-related barriers, the information about the health consequences of unemployment and job insecurity and our current approaches to transferring this research to potential users are not without their weaknesses. While the research literature on the health consequences of unemployment and job insecurity has grown and matured over the past decade, these studies examine associations; they do not evaluate the effectiveness of policy interventions [see, e.g. Brownson et al. about the importance of this additional information (Brownson et al., 1997)]. Very few such evaluations have been conducted (Gepkens and Gunning-Scheepers, 1996) and some participants suggested that they would require such information before acting. Moreover, effective approaches to the transfer of research information (Crosswaite and Curtice, 1994; Nutbeam, 1996) are rarely used.

The success of efforts to build employment-related healthy public policy also appears to depend on how decisions are made. In particular, success depends on institutional features like the extent of fragmentation of jurisdictional authority between departments and levels of government, the pattern of existing government partnerships, and the extent of accountability for addressing cross-departmental or cross-governmental issues. To overcome this barrier, several health policy makers suggested that steps need to be taken to establish cross-departmental or cross-governmental accountability for health. Again, action here depends in part on overcoming idea-related barriers.

Our methodological approach to identifying barriers to building employment-related healthy public policy addresses many concerns raised in the health promotion research literature (O’Neill and Pederson, 1992; Stevenson and Burke, 1992; McKinlay, 1993) and offers three strengths.
First, the responses were grounded in real-life experiences. Interviews were conducted with policy makers and NGO executive directors who have been in positions where they (could) have advocated using or used information about the health consequences of unemployment and job insecurity. Moreover, the interviewer always prompted participants to speak about specific initiatives, not in general terms. Secondly, the responses were grounded in an understanding of the true health consequences of unemployment and job insecurity. Participants were informed and prompted by non-technical summaries of research findings about particular aspects of the relationship between unemployment and health or job insecurity and health. Thirdly, the responses were not biased towards barriers rather than opportunities. Citation of barriers was elicited indirectly by open-ended questions about how this information had been or could be used in particular initiatives, not directly using questions about barriers per se.

Our approach also had weaknesses. First, while we identified participants so as to provide a range of views across levels of government and departments within a level of government for policy makers and across roles in the policy process for the executive directors of NGOs, it is not necessarily representative of the larger study population from which our sample was drawn. Response rates, while reasonably high for federal health policy makers, were low for employment policy makers and NGO executive directors. Secondly, our inductive approach to examining the responses to the semi-structured questions was focussed on identifying barriers to building healthy public policy, not on identifying whether a barrier operated independently of other barriers or to measure the relative importance that respondents attach to one barrier over another. The identified barriers may therefore not operate independently or with the same influence.

CONCLUSION

We draw from these results three observations about building public policy in other policy domains. First, to build employment-related healthy public policies, health policy makers should act as the intellectual leaders within governments to help frame information about the health consequences of other departments’ decisions in the language of these other departments’ values. The conflict between information and the values of those who could respond to such information was cited by policy makers and NGO executive directors more frequently than any other barrier to the use of information about health consequences.

Secondly, health policy makers and advocates of employment-related healthy public policy should argue for institutional innovations within governments which will ensure that health consequences are not left out of decision-making processes. Policy makers and NGO executive directors offered many suggestions: advocate interdepartmental initiatives like the current initiative related to social cohesion in the Canadian federal government, advocate intergovernmental initiatives like federal/provincial demonstration projects, support improvements in the ease with which existing government partnerships can be modified to allow for the development of new partnerships as new information becomes available, and establish accountability for cross-departmental or cross-governmental issues like the health consequences of government decisions. Intersectoral collaboration, while not without its challenges (Delaney, 1994; Kreisel and von Schirnding, 1998), offers the potential to draw the attention of those in other policy domains away from an exclusive focus on their traditional measures of success or failure and towards a broader focus that includes health consequences.

Thirdly, health policy makers and advocates of healthy public policy should monitor the support of the public, bureaucrats, and stakeholders who may be affected by initiatives that are proposed on the basis of information about health consequences and be prepared to address a lack of support when the public, bureaucrats and stakeholders are faced with new information. Although interest-related barriers are not the most commonly cited barriers to building healthy public policy, they certainly can’t be ignored. Potential winners and losers with political influence will never be lost from the policy development process (O’Neill, 1987). As Nutbeam has argued, advocates of healthy public policy should also work to ensure that they (i.e. these advocates) are not lost from this process (Nutbeam, 1997).

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APPENDIX

Non-technical summaries used in the interviews (with related references from a systematic review).

Unemployment

Unemployment has been consistently linked to poor health. Regardless of how health was measured, studies have found that unemployed adults are at higher risk of suffering a decline in their health than their employed counterparts. After losing a job, unemployed adults were found to experience increases in cholesterol levels, blood pressure and weight (Kasl et al., 1968; Kasl and Cobb, 1970; Morris et al., 1992). In addition, adults who experience unemployment have consistently been found to die earlier than adults who did not experience unemployment, all other things being equal (Moser et al., 1984; Moser et al., 1986; Costa and Segnan, 1987; Iversen et al., 1987; Moser et al., 1987; Martikainen, 1990; Stefansson, 1991; Morris et al., 1994; Martikainen and Valkonen, 1996; Lavis, 1997). Unemployed adults were less likely to abuse alcohol or smoke than the employed (Iversen and Klausen, 1986; Kaprio and Koskenvuo, 1988; Morris et al., 1992), most likely because of the high costs associated with such behaviours.

Related question: Given this information, which suggests that Canadians’ health status could be improved by reducing the chances of people losing their jobs (through education, retraining or other measures) or improving their chances of finding a new job, can you discuss any current initiatives which could be modified, or address potential new policies that could be supported by this information?

Job insecurity and/or the anticipation of unemployment

Job insecurity can negatively affect health and have an impact on the bottom line of employers. The risk of heart problems and sickness absence have been found to be higher among individuals with insecure jobs than those with secure employment (Ferrie et al., 1995; Owens, 1966; Ferrie et al., 1998). Moreover, many of the negative health consequences of unemployment, such as increases in cholesterol levels (Kasl et al., 1968), are concentrated in the anticipatory phase before unemployment (i.e. the period after notification of job loss but before actual job loss occurs).
Related question: Given this information, which suggests that job insecurity and the anticipatory phase before unemployment can have important health consequences, can you discuss any current initiatives which could be modified, or address potential new policies that could be supported by this information?

Pathways through which unemployment may affect health

Unemployment may affect health either directly through biological mechanisms or indirectly through other health determinants. These biological mechanisms can include stress-related occurrences such as an increase in blood pressure, changes in the levels of chemicals found in the brain and alterations to hormone levels in the blood [e.g. (Kelly et al., 1997)]. More importantly for policy makers, unemployment may lead to a drop in income, and income has been shown to be a powerful determinant of Canadians’ health status [e.g. (Wolfson et al., 1993)]. For individuals who rely on their work colleagues for social support, unemployment may lead to a loss or reduction of social support and a related reduction in health status [e.g. (Berkman, 1995)].

Related question: Given this information, which suggests that unemployment may lead to a reduction of income or a loss of related social supports, both of which are important determinants of health, can you discuss any current initiatives that could be modified, or address potential new policies that could be supported by this information?

Particularly affected groups or areas

The context within which unemployment is experienced makes a difference to how unemployment affects health. Several studies have shown that individuals who experience unemployment in areas or periods with low unemployment rates suffer more negative health consequences than individuals who experience unemployment in areas or periods with high unemployment (Iversen et al., 1987; Morris et al., 1994; Lavis, 1997).

Related question: Given this information, which suggests that the context in which unemployment is experienced makes a difference, can you discuss any current initiatives that could be modified, or address potential new policies that could be supported by this information?