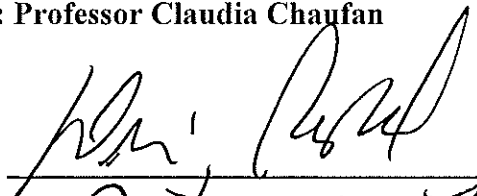# A SEED WILL GROW IN PROPER SOIL:

EDUCATION AND HEALTH LITERACY AS THE STARTING POINTS FOR

STRUCTURAL REFORMATION THROUGH THE ADDRESSING OF THE SOCIAL

DETERMINANTS OF HEALTH WITHIN CANADA

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Abstract

  The purpose of this paper is to show that due to the lasting effects it has on health, well-being, critical thinking skills, and political advocacy, the structure of education in general and a focus on health literacy in particular should be a fundamental starting point when attempting to improve and promote the health of Canadians. Of special attention should be understanding the pathways by which public policy and the social determinants of health shape health and well-being. Possessing an adequate level of education and possessing critical health literacy are important determinants of health which improve other social determinants throughout the life course. To properly address the health problems we now face in Canada, we must acknowledge the effects of the social determinants of health and public policy, as well as promote education and political activism on these factors. Improvements in education and critical health literacy can create a better environment for emancipatory ideas and strategies to promote health and alter the structure of society. Exposing the public to such concepts will help gain social and political support for the structural changes that are needed in Canada to address these complex and lasting problems in society now and in the future.

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Introduction

      Without the benefits we can reap from education and knowledge being made available to Canadians, we are doomed to repeat the sad chain of events that has come to be our history of health and educational policy within Canada. Through the course of this paper I will show that because of the lasting effects it has on health, well-being, critical thinking skills, and political advocacy, the structure of education in general and a focus on health literacy in particular should be a fundamental starting point when attempting to improve and promote the health of Canadians. Of special attention should be understanding the pathways by which public policy and the social determinants affect health, well-being, and the overall structure of society.

      Education on these factors, especially at an early age, can allow for growth and development in many other social determinants of health throughout the life course. Such education ensures that people not only have the tools and knowledge to make healthy decisions when they can, but also that they will be made aware of these complex social, political, and economic forces that negatively affect the health of Canadians. Repeated exposure to these ideas will help familiarize the Canadian public with these emancipatory concepts as they develop throughout their lives. This will, in turn, improve understanding, comfortability, and supportiveness in regards to such critical concepts and their language, particularly when brought about by politicians and educators. This structure of critical education should be enacted in the hope that Canadians will learn how to more effectively stand up and lobby for social and political changes that will address and improve health through the pathways of public policy and the other social determinants of health.

      I will use a philosophical and critical health literacy framework to analyze these problems and show that while people are responsible for their own individual choices and behaviours,

these actions are made within a more macro-level social, political, economic, environmental, and structural context. This is something that Canadians must be educated on and be extremely wary of when developing social and public policies. Knowledge of social determinants content would ensure the public would be more receptive of policies that support a more complex and comprehensive definition of health, and not merely the individual-focused biomedical and behavioural definition which currently dominates Canadian society.

Thus, educating the public (especially at an earlier age) about the diverse effects of the social determinants, and specifically the effects of education and public policy, will give rise to a healthier society through the lobbying for and implementation of more health-conscious public policies and improved social-welfare initiatives at state level. If people are more sensitive to these concepts, it will be easier for politicians of the future to establish and implement policies that are more focused on addressing health issues through public health policy and social welfare strategies. A focus on the social determinants of health is needed to remedy the problems we now face regarding the health and well-being of Canadians, as without such a focus these socially-rooted problems have little hope of being alleviated.

Improved critical education could give rise to a paradigm shift which could change the focus of society from building profit and reducing government involvement, to the betterment and survival of humanity through the establishment of health-conscious initiatives in the social and political realms. The policies which surround us shape our political and educational systems, and they have been shaped in specific ways for the benefit of specific parties within society. Therefore, we must be critical of our social environment and recognize why society is the way it is, as well as who benefits from such a structure. Before concluding, I will offer some possible reasons for why the importance of public policy and the other social determinants of health

continue to be under-recognized, touching on possible ways these social problems can be rectified. To outline these issues I will first explain how Canadians currently perceive health and what they view as the most influential factors on population health in Canada.

Canadian Perceptions of Health and Its Influences

Defining health, identifying its influences, and promoting it, has always been a contested subject. Canadians, like other nations, hold various grounded beliefs regarding health. The view that health is more than merely doctors, drugs, and hospitals has supposedly been widely accepted by the Canadian public, and yet so little still seems to be done to address certain health determinants outside of the spectrum of factors generally considered "health-related" (Snyder, 2015). Health is more than biomedical or behavioural factors such as diet, level of physical activity, and amount of tobacco use (otherwise called the "*holy trinity*" of risk factors), as health is also intimately tied to what has been termed the *social determinants of health*, or the conditions we are born into, grow up in, work in, and age in (Nettleton, 1997; Raphael et. al, 2008; Snyder, 2015). This includes factors such as level of income, housing and work conditions, level of political advocacy and power, social cohesion, and many influences at work within many diverse levels of society.

Most Canadians demonstrate knowledge of the "holy trinity" of lifestyle risk factors, but few are knowledgeable on the social factors which not only contribute to poor health, but also influence those same lifestyle factors more than any other element in society (Raphael et. al, 2008; Snyder, 2015; Snyder et. al, 2016). While it has been proven that about 50% of health outcomes are influenced by the socio-economic factors in a person's environment, Canadians still hold that the "trinity" of factors are the most influential on health, while the social

determinants are viewed as much less important (Chinn, 2011; Raphael et. al, 2008; Snyder, 2015; Snyder et. al, 2016). This type of thinking shapes how society addresses health problems, as well as affecting media, research, funding, educational and political structures, and numerous other elements of the social world.

Currently, the two top determinants of health reported on by print media in Canada are personal health behaviours and environmental factors (Snyder, 2015). In one Canadian study, only 1 in 3 Canadians acknowledged that social, economic, and communal factors influence health, while a massive 65-80% stated that lifestyle factors were extremely important to health (Snyder et. al, 2016). Likewise, from 1993-2014 only 113 news media articles published within Canada contained any social determinants of health material (Lucyk, 2016). In yet another Canadian study, adolescent students within a secondary school were given a questionnaire regarding the factors which they believed to be the most influential on health. Using the information they had been taught in the curriculum thus far, 44% of the responses given contained absolutely no social determinants of health material, and those that did include such material still gave much more influential weight to physical and lifestyle factors (Kenny/Moore, 2013).

These beliefs regarding health also influence and are reflected in our policies within Canada. Currently, most of the attention and funding for addressing health-related problems goes towards reducing the costs and demands regarding health care, addressing factors which focus on individual personal responsibility regarding health, and other such lifestyle-related perspectives in line with the "holy trinity" of risk (Kenny, 2012; Raphael et. al, 2008; Snyder, 2015). This clearly outlines how important the social determinants are in the minds of not only Canadian adults in either a teaching or learning role, but also in the minds of the children who will make

up subsequent generations of Canada and shape how the social determinants will be addressed in the future.

One such reason for this focus on lifestyle factors regarding health is that it is easier to demonstrate, understand, and act on the direct causation viewed between lifestyle factors and health than the vague and often indirect link between health and the social determinants (Kenny, 2012; Nutbeam, 2006; Snyder, 2015). If we see someone eating excessive unhealthy food, and we see them become overweight or sick, we determine it was their behaviour which caused their decline in health (Snyder, 2015). The poor health which results, however, is actually due to an entire system of social, political, economic, environmental, and structural factors which influence and feed off each other, so that demonstrating, understanding, and acting on such influences is much less direct or "clean cut" (Kenny, 2012; Snyder, 2015).

Additionally, such influences never simply go one way, but have a dialectical or reciprocal relationship, so that causes can be affected by their effects, and vice versa (Harden, 1996). Due to this type of relationship, the effects of facts and values are intertwined so that it is impossible to remove social value from the social world, making these relationships extremely complex situations to explain (Harden, 1996). Thus, it is harder for people to understand where their money and efforts should be aimed in order to alleviate the complex effects of the social determinants, resulting in a focus on addressing the direct causation observed between lifestyle factors and health.

Canadians often focus on health care and individual choice in regards to health, which are behavioural-related and downstream-aimed ideas focused where poor health manifests itself (Kenny, 2012; Snyder et al., 2016). These factors are not only easier to address but also provide direct and clear results relatively quickly, even if they do not address the underlying causes of

such problems in society. If the social determinants are to be meaningfully addressed, health professionals must first understand how the public within their respective areas perceive health inequalities and their views on the factors by which they are developed and maintained (Snyder et. al, 2016). This would help inform health professionals and policymakers on ways to increase public awareness of these inequalities, as well as help gather support for more socially-equitable health-related policies throughout Canada (Snyder et. al, 2016).

Understanding perceptions of health also allows health professionals to properly and effectively communicate these complex ideas across different social, political, economic, and cultural groups, hopefully demonstrating that health care is not always the solution to sickness (Snyder et. al, 2016). We currently spend half of all our federal dollars on health care, and as such, a solution to the better spending our annual health care budget should arguably involve more than merely treating sickness and health promotion (Das Gupta et. al, 2006; Snyder et. al, 2016). To better address these health problems requires a social determinants and critical health literacy framework within health, public, social, and educational policies in Canada.

Professionals inside and outside the health-related fields within Canada must first recognize and build on how the Canadian public understands these concepts in order to enact and support health-enhancing policies which focus on the social determinants (Snyder, 2015; Snyder et. al, 2016). Essentially, Canadians must create an environment which is receptive and supportive to these types of ideas in order for any strategies which focus on these problem areas to get the support and funding they require to be effective. Without changing how Canadians are being taught and how they learn, many will continue to be ignorant of the massive influence the social determinants have on their health, potentially robbing them of valuable tools to improve their health status throughout their entire lives.

There is also a severe lack of social determinants content being talked about and used in Canadian society and politics. Much of why these social problems develop and persist is arguably due to the structure of education and how it teaches us to think, act, and feel. To better understand this relationship, we must first explore what education is, why it is so important for health, and how education, society, and health are intimately linked. Following this logic, it will become clear why critical education is an essential tool in raising awareness of the social determinants and potentially changing the structure of society in the process.

What Is Education and Why Is It So Important?

Education is the process by which we learn about things in the world. We encounter and experience new objects, ideas, and ways of thinking, which in turn changes the way we live, think, act, and experience the world. Education deals with the mind and cognition, and involves the processes of knowledge, understanding, perception, and meaning (Barrow, 2015; Polakow, 1985). Through the traditional teaching method, we are taught by those who claim to have more experience than us, and we (hopefully) use this knowledge to understand, critique, and follow or oppose specific ways of thinking or acting. Education and knowledge, then, are arguably the cornerstone of all human life, and are intimately intertwined with health. Without education, experience, and knowledge, we could not navigate through the world we find ourselves in or learn how to acquire what we need to survive or live a healthy life, however that may be.

Through this process, we learn how to live. We are educated on what to do and what not to do by some form of authority who claims to have more knowledge than us. In this way, I mean education in a very basic and traditional sense; a progression of learning through experience from birth to death. We learn what to eat, how long to sleep, and what to avoid. We

learn these things either through normal everyday experience, such as conversing with friends or inquiring on the internet, or in the institutional realm, such as through schools or science. Education, then, is an essential factor in establishing a healthy and fulfilling life, and acting on one's own personal potential.

The Philosophy of Education

It is difficult to deny the benefit and power of education, and because of this, the concept and structure of education has been the subject of inquiry within philosophy since philosophical thought began. Plato said through Socrates that there is arguably a level of education and literacy that would be a good for all citizens in a society to possess to help them all live better, healthier lives (Barrow, 2010). This could be said to be a predecessor of the concept of educational or even health literacy, as improved education and literacy gives people more power over their lives and increases their likelihood of acquiring what they need to survive and live well.

Philosophers have also argued that education and the structure it follows contains a normative component and reflects a specific value structure in society. This is because educating people in something specific implies that something worthwhile is being taught in a morally acceptable way, and that what is being taught is not only what we *should* be learning, but what we should *want* to learn as well (Barrow, 2012). Essentially, the knowledge the teacher possesses is seen as a valuable gift which they can bestow upon the ignorant learner. To be educated is to possess a body of knowledge of why things are the way they are, knowledge which one uses to determine the *correct* way to handle a situation, and avoid the *incorrect* way (Barrow, 2012). Education was seen by Plato as a way of social control, and therefore a topic which should be contained within political discussions. Education helps citizens determine the correct things to

strive for and fear, and how to be good citizens within society, in an attempt to achieve social or cultural hegemony (Barrow, 2012; Chinn, 2011). Formal education teaches people how to live, which roles to fill, and what skills are valuable and desirable in the world.

The type of education we receive also affects our perceptions of the world and the people in it. In turn, the educational system is directly influenced by the political and educational strategies being implemented as well as the content being distributed, so that the ones who teach us are able to determine what kind of knowledge we are fed. This allows them to shape how and what we think, controlling our actions and even our ideas. These parameters are, in turn, influenced by the public policies in place and the dominating ideology, further shaping what content we are exposed to, what we see as right and wrong, and how we live our daily lives.

If this is the case, and it does seem to be, then obviously we would want to ensure our education is coming from an entity that is teaching us to do things in the most *proper* way, and not merely a way in which benefits those in power and furthers their own personal interests. Yet, this is exactly what is happening within Canada. This is why we need improved critical education, and why education and specifically health literacy are goals which public health initiatives cannot afford to avoid any longer: if we changed the way people are educated and the content they are being taught, it would affect the way individuals think and behave, while initiating change at the institutional and political levels, improving population health in Canada on an unprecedented scale. These goals could be achieved by adhering to some Freirean philosophies regarding critical pedagogy and emancipatory education as a means of increasing individual empowerment, political advocacy, and social control.

Freire's Concept of Critical Education

The philosopher and educator Paulo Freire had many revolutionary ideas regarding education and its power to control and shape society. His philosophies focused on the development of a pedagogy, or method of teaching, which attempted to prepare and emancipate the learner from any oppression they may encounter through the building of proper identification skills and critical thinking techniques (Giroux, 1978; Harden, 1996; Polakow, 1985). Termed *emancipatory* or *critical education*, Freire's philosophy was that education and literacy are useful tools of the existential-phenomenological tradition for establishing "what-its-likeness" (Polakow, 1985). The phenomenological concept of "what-its-likeness" means the attempt to understand "what-it-is-like" to be a person other than yourself, to establish the specifics of a person's individual world view in order to better understand how they see the world and the reasons for why they see it that way.

Each experience is experienced by a person in an individual way, and Freire believed education should be seen as a process of teasing out the individual perspectives of both the learner and the educator in order to better facilitate a combined educational process, building on the collections of knowledge of both (Giroux, 1978; Harden, 1996; Polakow, 1985). As such, education and literacy should be seen as "writing one's own text, speaking one's own word", and is intimately related to "meaning-making" (Polakow, 1985). Freire recognized that how and what we are taught can influence who we are, who we believe we can become, what is good or bad, and what we believe is possible or impossible in society.

Schools and the education they sell currently function to shape the perspectives and identities of the oppressed learners in an image designed by those who oppress them (Giroux, 1978; Polakow, 1985). Freire saw that a tool of such power could obviously be used to gain

social control through conformity and cohesion, if it were to be used a certain way. This would allow those who control education to shape the whole of society around their own interests.

Currently, much of education in Canada only prepares students to become cogs in the machine, filling roles they were designed, conditioned, or "destined" to fill. In Freire's educational structure, it is not supposed to be the words of the dominator (teacher) over those who are dominated (students) (Das Gupta et. al, 2006; Polakow, 1985). This is termed *traditional* or *banking education*, which sees the teacher as possessing a valuable gift which they can bestow upon the ignorant and inferior students, who can then memorize and regurgitate the information they have been given without much critical thinking (Das Gupta et. al, 2006). Such an authority attempts to make its own knowledge an objective truth to be imposed on others through oppression and conformity to standardized ideals (Freire, 1998).

If people are constantly told that they lack knowledge and that they are powerless to change things, they begin to think this way, discrediting their practical and experiential knowledge in favour of the knowledge and values of those who dominate and oppress them (Fahrenfort, 1987). Educators even justify their existence by defining their students as ignorant and in need of the knowledge they possess (Fahrenfort, 1987). The students also accept and reinforce this dependency by seeking out knowledge from these oppressive sources, and by failing to acknowledge or act against their own oppression (Fahrenfort, 1987).

In such a setting, there can be little tolerance or democracy, as there is always a right way, with all other ways being wrong (Freire, 1998). This criticism is not meant to completely discredit all fields of authoritative education and knowledge (such as science), but only to suggest that such ideologies do not depict the entire picture of reality (Freire, 1998). Traditional lecturing does not teach one how to critique or how to develop one's own meaning, but it can

provide information which is useful to raise critical consciousness, increase awareness, and alter everyday perceptions (Harden, 1996).

Instead, the processes of education should be seen as a cooperative and conjoined endeavour which incorporates many different ways of life, and involves more than merely having learners be "filled" with knowledge at the hands of their superiors. The freedom to be autonomous and make one's own decisions, however, is a responsibility which many shy away from as a result of their domestication, un-creativity, and submission (Fahrenfort, 1987). We prefer the safeness of dependency rather than the risks affiliated with making our own decisions and our own mistakes (Fahrenfort, 1987).

To counteract this, Harden offers five tools of empowerment which help teachers to actualize a shared vision between student and teacher which I believe fall in line with Freire's philosophies. The first tool is *positive self-concept*, which states that teachers who feel positive towards themselves, the content they teach, and they methods they teach it in are better equipped to meet the needs of their students (Harden, 1996). Secondly, developing *creativity* ensures that ideas are generated and not merely imposed, that new ways of doing things are developed, and alternative visions are imagined and harvested (Harden, 1996). Thirdly, educators must be responsible for ensuring *resources* such as funds, space, materials, and teachers are updated and kept in constant supply (Harden, 1996). Fourthly, *information* must be made available regarding current data and technical knowledge, helping students and teachers be aware of the usefulness of political advocacy and intelligence as a tool for empowerment (Harden, 1996). Finally, generating *support* such as written feedback, smiles, or advocacy and activism, while developing a supportive, inclusive, and trusting environment for both students and teachers to participate in (Harden, 1996).

Through Freire's cooperative process, both student and teacher become inhabitants of each other's personal worlds of meaning, using communal language to develop and mediate a shared and often slightly problematic reality requiring constant restructuring (Polakow, 1985). Following this, Freire advocates for an entire reformation of the relationship between educator and learner in order to rid ourselves of the master and slave relationship which our educational structure currently resembles (Polakow, 1985). This type of relationship only reinforces and maintains the ideology of the oppressors, so that the minds of students become imbued with the values of the dominant ideologies in society, and is itself a form of oppression shrouded in a cloak of false paternalism (Fahrenfort, 1987; Polakow, 1985).

Teachers are not to be seen as "givers" of knowledge, but as *problem-posers* who offer thought-provoking questions, build critical thinking skills, and not only encourage their students to ask their own questions, but to be critical of all information they receive (Das Gupta e. al, 2006). This does not mean that students are to resort to skepticism about everything they are taught, only that they must not accept anything merely because it is promoted by an authority. People must be taught to explore and answer the questions themselves, not always relying on an authority for answers.

Thus, educators must work to teach students to question answers, not merely answer questions, and present education as something one does, not something done to you (Beckett, 2013; Das Gupta et. al, 2006). In doing so, students and teachers can develop a mutual process which presents the knowledge sought and gained as mutually owned, instead of being the sole property of the educator or dominator (Das Gupta et. al, 2006; Polakow, 1985). The teacher must open up and be receptive to the ideas of their students, for we cannot listen to others if we only see ourselves as important (Freire, 1998).

Both the student and the teacher must practice humility and tolerance, while remembering that we all know something, no matter one's intellectual or social level (Freire, 1998). Doing so helps us from becoming too entrenched in our own truth to the point that the opinions or beliefs of others cease to matter (Freire, 1998). We must learn to work and live with other ways of life in order to be receptive and inclusive to all types of ideas and concepts, while still being critical of their foundation (Freire, 1998). The educator must work to create an inclusive and supportive environment for critical thinking, an environment that allows students to offer opinions which differ from the generally accepted "norms" regarding knowledge and education, and facilitate the exploring of these various alternatives in an academic setting (Das Gupta et. al, 2006).

This type of education is termed a *dialogical encounter*, which involves an ongoing process of education through a shared dialogue between teacher and learner (Polakow, 1985). In such a phenomenological structure, lived language and experience has as much value as academic language or experience, so the world views of both teacher and student are equally valuable in the development of knowledge (Polakow, 1985). This allows each side to have equal opportunities for their voices to be heard and aid in the shaping of the educational process in whichever way they determine to be beneficial to society, after lengthy processing, critiquing, and debate. Additionally, this type of structure views education not as something which has an end when classes finish, but as an ongoing, lifelong process which inspires one to continuously criticize, know, and re-know the subjects of inquiry within their reality, to analyze their own world view and recognize the foundational social influences on it (Beckett, 2013). This process would include many instances of restructuring so as to address new and developing issues, keeping the social environment current and receptive to changes in society and knowledge.

Following this, Freire believed we should use our individual creativity to discover new and different ways to do things rather than merely accepting the way things have always been done. He advocates for using our imagination to "create an alternative vision of a world of possibility rather than accepting a 'limit-situation' of fatalism and despair" (Polakow, 1985). Since authoritative education influences thoughts and behaviours, Freire believed in critiquing the way society is currently structured, and envisioning ways in which it could be structured differently or more efficiently (Polakow, 1985). This helps people develop into creative thinkers, potentially uncovering new and improved ways of organizing society or addressing currently unsolved problems. Due to the way it helps create alternative world views, creativity is extremely important for education and health literacy. In fact, creativity could arguably be considered the basis for critical thinking, as it is only when an alternative can be envisioned that the norm can be questioned and alternatives to the norm can be created or implemented.

This is in response to the idea that all knowledge structures are ideological and political in nature, as they describe how reality operates, what is possible in it, what is valuable in it, and what level of authoritative power and control is justified (Giroux, 1978). Working with teachers, texts, or educational structures is not a neutral activity, as all forms of textual and educational arrangements are structured on presuppositions about the way the world is and how it ought to be (Roberts, 2016). Even this very text follows my own perceptions of politics, society, and value. Deciding what, how, and why texts should be read or which educational structures should be used is inherently a non-neutral, value-laden, political, interest-serving process (Roberts, 2016).

To Freire, as with Nietzsche, the relationship within knowledge between the doer, the receiver, and the external world must be acknowledged, as it is only through this relationship of factors that we can gain knowledge at all (Giroux, 1978; Nietzsche, 1977). Knowledge is only

possible in the object-subject totality, as without a perceiver to perceive, the object cannot be perceived or known (Giroux, 1978; Nietzsche, 1977). As such, all facts embody the knower as well as the doer, and reflect the specific values of some specific party (Giroux, 1978). To deny this is to deny the intimate connection between perceiver and the external world, as well as the importance that will and desire has on every perception we have (Giroux, 1978; Nietzsche, 1977). We can see bad things as good if we are conditioned a certain way, showing that our value towards or desire of a subject can change our perception of it.

Each educational structure teaches a specific process of learning, and can teach people to be critical or submissive towards authority. The ideology we are currently fed by those in power supports conformist-type thinking, not critical thinking which pushes us to critique why things are the way they are. The current content, pedagogical styles, and forms of evaluation also function to distribute and reinforce the self-depreciating fatalism and misdirected powerlessness and violence which pervades society (Giroux, 1978).

The existing structure of society purposely keeps the poor unhealthy and uneducated while the rich and powerful reap the benefits of exploiting the vulnerable populations of the world (Chinn, 2011; Polakow, 1985; Raphael et. al, 2008). This type of social structure also conditions people to believe it is okay, justified, or even necessary for some groups to dominate others, and that this is just the way society is (Giroux, 1978). All education, then, begins with the question of meaning and the nature of knowledge itself, as decisions must be made about whose reality is being validated, and which values are being deified by the specific type of knowledge being presented (Giroux, 1978). In this way, schools work to reproduce and legitimize the dominant consciousness, creating a motivational structure which attempts to align individual needs with societal needs, teaching us how to live, what to buy, and what to think (Giroux,

1978). To undo these effects, we must first make the public aware of the conformity-enhancing mechanisms used in our educational structure, so that the public can act readily on these forces.

To facilitate this counterattack on the controlling effects of education, Freire encourages the development of skills related to what he calls the "*auto-critique*", which is a process of examining and critiquing the factors which guide one's own beliefs, thoughts, actions, and values (Polakow, 1985). Seeing the educational structure as a process of legitimizing the dominant culture in society within the larger socioeconomic context allows one to recognize the source of this problematic process and how to work towards remedying it (Giroux, 1978). Beginning to examine one's own lived experience and their perception of the world allows one to see and move past these preconceptions to encompass a broader and more interconnected perspective on the attributes of unjust or unhealthy societal conditions (Polakow, 1985). Only by teaching people to critique their surrounding environment will it be made clear that there are many pervasive societal issues which could be better addressed through the restructuring of various aspects of society.

If no one knows there is a problem with the way society is organized, nothing will be done to change it. This type of creativity, critical thinking, and awareness is extremely important for critical education, for it makes it easier to move out of individualistic understandings of health and responsibility (Polakow, 1985). Furthermore, this shift in individual ideology and belief is a necessary step towards developing more communally based and socially equitable educational structures within Canadian society, as well as implementing strategies which take Freire's philosophies to heart, as all of these ideas stem from perspectives beyond individualistic-understandings of health and society.

School is important for more than merely teaching skills or knowledge. It also has the potential to teach liberation and emancipation by improving the power of individuals to shape their own meaning or world view, while creating an environment which supports and enables the development of their powers of self-determination through their ability to critically analyze and act on the reality they perceive (Giroux, 1978). To do this, historical knowledge must be used to create new knowledge, presenting a social context reading of society which outlines and critiques the human norms and interests within which knowledge is situated, so that we may be critical of whose interests are being furthered by society being organized in such a way (Giroux, 1978).

The public must recognize that the seeming objectivity of knowledge is used to legitimize the belief or value system at the core of our bondage within society, a process which attempts to remove the norms, values, and interests of the social context which underpins and shapes the oppressive structure of society (Giroux, 1978). This process attempts to veil the vested interests of those in power, who have shaped society to serve their personal agendas, so that the public continues to act as if the current structure of society is neutral, legitimate, or even necessary. Therefore, Freire urges us to always be critical of where knowledge comes from and whose interests it serves, views which are facilitated through his idea of critical education as a means of individual and communal emancipation.

Following his existential-phenomenological perspective, Freire offers an eloquent quote which I believe succinctly sums up his philosophical view on the fluctuating nature of education, critical thinking, the dialogical endeavour, life, value, and meaning itself. He states:

I like to live, to live my life intensely – for me the fundamental thing in life is to work and create an existence overflowing from life, a life that is well thought out, a created and

recreated life – a life that is touched and remade in this existence. The more I do

something, the more I exist. And I exist intensely. (Polakow, 1985)

This means that the life, reality, or world view we create must be one which has been deliberated on and restructured, made and remade, so that it includes many diverse and critical perspectives so as to aid in living a healthy and fulfilling life. We must be critical of our surroundings, and the effect it has on our lives, and work to live as intensely and freely as we so choose, without the threat or fear of outside authorities breeding us to exist a certain way or to fill a specific role in society. We must live as creative beings, for as Nietzsche says, we are the creators of value (1977), and as such we must be wary of this fact and acknowledge that anything we are told depicts a particular value structure and world view. No authority is different, for whatever they choose to tell you, it is an attempt to change you to fit their idealistic perspective.

To face such a colossal task may seem an impossible feat, but we must start somewhere. Freire firmly believed that big actions must start as small actions. Local knowledge can influence both the practice and teaching of advocacy in society, and build on other ways students can enact change, demonstrating how small acts can build momentum and start to affect larger issues if they are given the support they require to flourish (Polakow, 1985). Questioning, critiquing, discussing, and discovering knowledge inside and outside the classroom can lead to changes in the social, political, professional, and clinical world, eventually even working to help people analyze the broader social environment and advocate for social and political change (Das Gupta et. al, 2006). An educational structure of this kind could create critical thinkers who will continually work to create or find their place in society, as well as attempt to improve the education of people to be healthy and involved citizens (Das Gupta et. al, 2006). A focus on

these Freirean concepts will arguably create a more inclusive and purposive setting within society for the improvement of numerous areas related to education and the social determinants of health.

This dialogical structure could be extremely useful for structuring not only education, but also research, media, public policy, medical professions, and a mass of other fields as well. This framework supports an inclusive environment which prevents against a broken network of alienated discourses where each field, perspective, or theoretical paradigm is secular or mutually exclusive (Polakow, 1985). Separating such fields creates numerous systems of dominating language which renders any type of fusion of ideas practically impossible, as each field sees itself as separately and individually valuable (Polakow, 1985). In the times where society does arguably pool the resources, knowledge, and attention from all possible areas of study, these efforts are often only focused on a few, moderately affected areas within society rather than those areas which need aid the most (Polakow, 1985). Doing so robs many other areas of society of the immense benefits such collective and multidimensional efforts could provide.

Unfortunately, Canadians still currently follow this logic when addressing education, knowledge, or health and its influences. They may occasionally pool resources or knowledge from different areas related to health, but far too often the goals of these collective efforts are based on merely biomedical and behavioural understandings of health. Our society focuses on a few specific areas of health and often shuns all the knowledge and resources gathered from fields not generally considered "health-related". Instead, we could be using all available data gained from all the areas of society which arguably influence health (mainly the social determinants) to create a more comprehensive idea of health and its influences. Essentially, professionals within the multitude of different health-related and educational areas of Canadian society must work to

bridge the gap between actuality (practice) and abstraction (theory) within their respective fields (Polakow, 1985).

Separating these different discourses also causes professionals to read and write potentially useful articles for "closed worlds of meaning" (Polakow, 1985). Seeing different fields as mutually exclusive forces much of the valuable content gained from these areas to remain within their respective fields, only to be utilized by those professionals who can discover such content and both comprehend and act on the material and various knowledge gathering and evaluation techniques specific to each discourse. Doing so also causes much of this content to remain purely theoretical, with little or no practical application to support it, thereby becoming useless, meaningless, and perpetually unactualized (Polakow, 1985). This is referred to as the "culture of silence" which currently permeates most educational institutions, a belief which professes all theory and no action (Polakow, 1985). These are all factors which educators and other professionals must work to address within their own professional fields to allow for the improvement of numerous social determinants of health within Canada.

Education, Critical Health Literacy, and Health

The ability of any person to properly understand the factors that influence health, and how to follow healthy social, political, and lifestyle-related advice from professionals of any kind, is determined by the level of education and cognitive ability a person has. Educating people on health and what influences it gives people the knowledge to act in accordance with healthy lifestyle parameters, as well as giving them the ability to understand, identify, and hopefully avoid factors which negatively affect health at numerous levels of society. Following from this perspective, *health literacy* is a concept which is grounded in education and cognitive abilities.

Improvement in health literacy means more than the transfer of health-related information, or the ability to read pamphlets and make appointments properly, but includes improving the conditions in which people can access health information and increasing their overall capacity to use it (Chinn, 2011; de Leeuw, 2012; Nutbeam, 2006). Health literacy is the development of "personal, cognitive, and social skills which determine the ability of individuals to gain access to, understand, and use information to promote and maintain good health" (Nutbeam, 2006). Strategies which follow this model improve knowledge and understanding of the social determinants of health, change attitudes and beliefs in relation to the performance of health behaviours, increase empowerment, and provide improved autonomy (Chinn, 2011; Nutbeam, 2006). Health literacy is also meant to provide individuals with a mechanism of information appraisal, so that they can and will assess the reliability, validity, credibility, and applicability of the information they are provided inside and outside of the health spectrum (Chinn, 2011).

Such ideas are also in line with many of Freire's philosophies, and recently there has even been a revival of his ideas in the public's eye (Chinn, 2011). This is mainly as a reaction to an individualizing trend of consumerism regarding a health and educational system which not only creates health inequalities, but which also benefits those already in possession of social, material, and cultural assets and power (Chinn, 2011). Thus, if we educate the public on the causes of disease, the influence of power on society, and the effect social and public policy has on health, making this type of critical information freely and massively available, individuals will be able to make better decisions regarding their own level of health and the policies that are established within their respective communities.

Teaching people about these issues, especially at an earlier age, will allow them to become more familiar with such concepts, hopefully working them into everyday life the way we

currently do with the lifestyle and biomedical perspectives on health. It has been shown, partially as a result of our being taught to be submissive and uncritical towards authority, that people use biases in their decision-making processes and critical judgements in everyday life (Chinn, 2011). People prefer "credible" health and information sources which are familiar, or associated with a trusted "brand", and which carries institutional "authority" in a specific field (Chinn, 2011). Even though many people can identify ways to test the trustworthiness of information gained through sources such as the health field, the internet, or friends, these techniques are seldom used in everyday practice (Chinn, 2011). We simply seem to trust what we define as usual or normal in our society.

This affinity and trusting attitude towards what we are familiar with can be explained through the concept of the *mere-exposure effect*, which states that people become familiarized with phenomena they encounter repeatedly, especially on a regular basis (Zajonc, 1965). According to this idea, repeated and unreinforced exposure to a specific stimulus can lead to a more positive attitude towards the stimulus as we become "normalized" to it (Zajonc, 1965). Simultaneously, a person can develop positive feelings towards this familiar stimulus while developing negative feelings towards stimuli which are unfamiliar to them (Zajonc, 1965). Repeated exposure increases familiarity, while even similar ideas not exposed are rated lower (Zajonc, 1965). This is as long as exposure to the stimulus does not become too excessive, as overexposure to a stimulus can result in a negative and adverse evaluation (Zajonc, 1965).

In one English speaking study, subjects were shown three types of images: nonsense characters, nonsense Chinese characters, and pictures of faces (Zajonc, 1965). These were presented in a counter balanced order to subjects a number of different times (between 0 and 25), and rated on a scale of liking (Zajonc, 1965). The results showed that the more often subjects

saw a particular image, even nonsensical ones, the higher the rating of liking they gave it

(Zajonc, 1965). As argued by Zajonc, this process of liking the more familiar stimuli can

arguably be linked to an exceedingly useful instinct in our basic evolutionary nature as animals.

Being exposed to a stimulus previously allows for the quicker processing of information and the

quicker identification of elements in our environment (Zajonc, 1965). Humans like to categorize

things because it allows us to quickly determine whether something is friend or foe. This is a

survival technique which has its foundation in our fight or flight impulse as a response to

predators and other dangers.

We feel safer around familiar stimuli because we supposedly understand how they

operate and what dangers they pose in a more enlightened regard. As such, humans seem to

prefer things which they can process quicker, so they choose familiar options more often than

not. This can be seen in a person's tendency to choose what they know, rather than take a risk on

the uncertain. For example, we may order the same item at a restaurant time and time again,

instead of taking a risk on a new choice which we may not enjoy as much as our previous, well-

established choice. This seems to outline the way society feels towards much of health and health

care: that the current state of affairs may not be perfect, but altering them to a state which we

have no experience with seems a risk too high for most to take. Better that we simply stay where

we are, where we know it is safe, rather than risk disaster.

Public policy and social awareness is no different in this regard. People seem to prefer

types of policies, politicians, and political ideas which they have encountered before, are familiar

with, and understand better than those which are foreign to them. People do not seem to trust

politicians (and history has not served this profession well), especially politicians with ideas and

initiatives which use foreign language and concepts to address problems the public did not even know existed.

This partially explains why the behavioural and lifestyle-related health information continues to receive more attention than the social determinants of health framework. People are not familiar with social determinants content, and so when politicians or teachers begin speaking about addressing such complex and seemingly massive problems in society, the public begins to shy away. They do not like to hear information regarding health which is unknown to them, because this classifies it as "dangerous" information, as it can affect not only their lives but the structure of society itself. Of course such a daunting possibility would be something to be fearful of, but most people seem to use this alone to justify being content with the way things currently are. Most would prefer to be satisfied with the status quo rather than risk making things worse, even if there is also a chance to make things exceedingly better.

The environment which these types of ideas are delivered into must therefore be receptive to their nature, not dismissive of new philosophies. Like a seed, these critical ideas require fertile ground in order to sprout, and an idea must be put forward in a time in which it will be properly received and taken seriously by those who encounter it (Coburn, 2010). The social world is not static, and it fluctuates in regards to the ideas we produce, which are specific to our upbringing and the environment we exist in, so that different groups, nations, and environments create different kinds of people (Coburn, 2010). If the critical ideas I have argued for are developed within and presented to an environment which is hostile to such philosophies, they will never take root in the minds of the public, and no one will fight for their necessary implementation in order to avoid preventable suffering and death on a massive, unprecedented scale.

To create this "receptive" environment, we must educate the public on the social determinants of health in *all* its forms. Such education will create more informed citizens, who can push for policies that promote both education and action on other social determinants of health. Influencing public policy is extremely important as it can change the way people understand societal problems and how they are addressed (Raphael, 2009). Health education, then, should promote health by improving health literacy and developing effective social, educational, and political strategies aimed at the social determinants (Gould et. al, 2010; Nutbeam, 2006). Such campaigns to educate people on disease prevention at the micro-, meso-, and macro-levels would tackle a variety of issues. One example would be promoting maternal and child health through the development and promotion of vaccinations (micro-level), safe communities (meso-level), and public policies that support social welfare such as child care and adequate wages (macro-level).

Possessing health literacy would allow for the making of more informed and healthier decisions throughout the life course, thereby becoming an important determinant of health in itself. Critical citizens would be more likely to acknowledge these social determinants of health, connect them to personal experiences, and be more receptive to and supportive of policies which address these social issues (Kenny/Moore, 2013; Mogford et. al, 2011; Snyder, 2015). It has been proven that educating youth on the social determinants has led to improved health literacy and increased political advocacy on their parts (Kenny, 2012). Thus, health literacy should be a goal for health promotion as it may have powerful and lasting individual, community, and societal effects (Kenny, 2012; Nutbeam, 2006).

Historically, however, this has not been done in Canada. Attention to health literacy as a goal of health promotion is fairly recent. Early campaigns focused on lifestyle changes and were

based on simplistic understandings of the connection between the communication of information and behaviour change (Nutbeam, 2006). Emphasizing behaviour change at the expense of broader factors, it was also limited to the assumption that merely providing this information would be sufficient to change behaviour. Eventually, a more socially oriented perspective was worked into health promotion -- "the social context of behavioural decisions" (Nutbeam, 2006). These initiatives focused on helping people develop better personal and social skills, allowing them to make more positive health choices, after seeing that initiatives which focus merely on information communication and education failed to alter behaviour (Nutbeam, 2006). Many of the strategies implemented over the years have also been focused on advanced students, therefore requiring a considerable amount of investment in a formal education, and putting them out of the reach of many health service users (Chinn, 2011). This has led us to the current situation within Canada regarding health literacy and education.

Evidence has begun to mount regarding the social determinants and their effects on health, and health promotion and education initiatives now need to properly recognize and address the effect health literacy has on the health status of citizens. Doing so will help remedy the negative health outcomes that have resulted from the current social, political, economic, and educational situation within Canada. If we are to properly address the causes of poor health that result from poor levels of health literacy in Canada, initiatives of the future must regard health literacy and the social determinants as a fundamental element of health promotion and education.

To do this, however, is no easy task. Strategies must be developed which consider biomedical and behavioural factors as well as the social determinants of health, establishing a comprehensive plan regarding health promotion at all levels of a person's life. Nutbeam includes an example of what such initiatives would look like, stating that in order to address population

health in regards to smoking, we must develop "efforts to communicate the risks to health of tobacco use, [and] also include strategies to reduce demand through restrictions on promotion and increases in price, to reduce supply by restrictions on access (especially to minors), and to reflect social unacceptability through environmental bans" (2006). Initiatives such as this address the biomedical and lifestyle factors related to health, as well as demonstrate how social, political, and environmental factors influence these factors, communicating valuable health-related information to individuals to be used at their own discretion (Nutbeam, 2006).

The link between knowledge of the social determinants of health and level of health status is not an easy thing to provide evidence for, but it can be clearly understood how such factors can influence not only health, but many other areas of society as well (Chinn, 2011). Following from this, knowledge of the structural factors which work against us may very well start to alter the feelings of shame, self-blame, and powerlessness that many people feel in regards to the restructuring of society and the improved addressing of health-related problems (Chinn, 2011). If it is made clear that health is not always a result of individual or biological factors, as also being a result of factors arguably out of our control, it may change the way we feel about ourselves and hopefully cause the "civic-minded" to act against health inequalities and other social injustices (Chinn, 2011).

This could potentially push people to better assess and account for their own individual motivations, and ensure that they are performing the proper amount of advocacy at the proper levels of society for the right reasons, while also being critical of these factors in others (Chinn, 2011). This will work to improve public understanding and government approval for intervention in these areas so that a requirement can be set for government-level strategies and investment in order to better address structural and health-related inequities (Chinn, 2011). As Freire believed,

a critical consciousness in regards to these issues is a necessary and sufficient precursor to proper levels of community empowerment, critical decision making, and health promotional activism in the social and public realms (Chinn, 2011; Polakow, 1985). This will hopefully begin to alter society from its fundamental mechanisms and rework them to benefit all of society, not merely those currently at the top.

As an adjunction to health literacy, Chinn offers a concept which she calls *social capital*, which can be defined as the degree of connectedness, or the quantity and quality of social relations between both persons and organizations, an individual experiences within their community (2011). Social capital, much like health literacy, is thought to mediate the effects of material and social disadvantage, as well as health inequalities (Chinn, 2011). This is done through the relationship between the perception of one's environment and the beliefs one holds in regards to it. If a person sees their environment as inclusive, trusting, and helpful, they may be more likely to participate in society and work towards communal goals and improvements within the community (Chinn, 2011).

According to Chinn, there has been an increased level of social capital found to be associated with higher levels of health literacy within community groups, meaning that participation in these groups is likely to increase critical health literacy, and vice versa (2011). Again, these ideas fall in line with Freire's philosophies, as empowerment and community participation are core goals of the concept of health literacy. These ideas also relate to Freire though the process of praxis, or the adding and subtracting of elements of a whole, restructuring it with old and new attributes which work with and feed off each other (Chinn, 2011; Polakow, 1985). By acknowledging and promoting these factors, each individual in Canada can develop the means to control their own futures and live much healthier lives.

Social capital and health literacy, then, should be seen as central pursuits of health education and promotion within Canada, as these factors set the backdrop for the development of numerous other social determinants throughout the life course and allow for the increased autonomy of Canadian citizens. Therefore, there must be a shift within public health promotion to view it as more than an individual achievement, but as a socially contextualized event involving people within a complex network who are cooperating and working towards common goals, values, and cultural practices, using their combined skills to make sense of and act on information, texts, and social or political movements (Chinn, 2011). In this way, health literacy combines the individual level of behaviour and health care needs with the collectivist level of health promotion and the social determinants of health (Chinn, 2011). Following such a structure properly acknowledges the power of this duality of spectrums, giving weight to both sides, not merely one or the other.

As mentioned before, health promotion continually seems to focus on only the behavioural and biomedical aspects related to health. This is also partly due to the failure of educational programs in the past, causing the role of health education and health literacy in public health initiatives to be consistently downplayed and undervalued (Nutbeam, 2006). Health literacy is seen as providing limited prospects for health, contributing only to improvements in individual knowledge regarding the risk factors of disease, and as having a limited role in promoting behaviour change in relation to those same risk factors (Nutbeam, 2006). Seeing health literacy in this way fails to acknowledge the importance of education in public health promotion, and how such initiatives can increase a person's level of empowerment and autonomy (Nutbeam, 2006). Therefore, health promotion and education strategies must properly acknowledge the importance of these social, political, and environmental factors if they wish to

make any lasting improvement on population health in Canada, as these social problems will persist otherwise.

Education of this type affects numerous aspects of social and political life. A higher level of health literacy, and thus a better understanding of the causes of health (specifically the social determinants), influences political ideology and promotes political advocacy and lobbying for the implementation of healthier public policies, leading to the alteration of legislation in order to better address these health concerns (Nutbeam, 2006). Following this, Nutbeam includes another example of what initiatives of this kind would look like, stating that these strategies would be aimed at improving quality of food choices available in schools and at worksites, and intervening with food retailers to improve supply and promotion of healthier food (2006). Strategies that focus on this multitude of factors place "health education and communication into the wider context of health promotion, and highlights health literacy as a key outcome from health education" (Nutbeam, 2006). This attacks these health concerns from both sides, affecting the behaviour of individuals and the environment they operate within to improve health outcomes (Baum, 2007).

Within the overarching concept of health literacy, there are several types of literacy that can be further defined. These definitions are tied to what health literacy allows us to do in specific circumstances, and each definition receives different levels of support and recognition within the health literacy realm (Nutbeam, 2006). These definitions are valuable because "how we define and measure health literacy is both dictated by and influential on the content and methods of health education" (Nutbeam, 2006). Nutbeam explains three separate but related definitions of literacy. *Basic* or *Functional literacy* involves the basic skills of reading and writing which enable people to function effectively in everyday experience (Nutbeam, 2006).

Communicative or *Interactive literacy* involves advanced cognitive, social, and literacy skills to participate in regular activities, extract and derive meaning from information and communication, and to apply newly gained information to new situations (Nutbeam, 2006). Finally, *Critical literacy* involves advanced cognitive and social skills to critically analyze information, allowing people to properly use the information they have encountered to increase the control they exercise over their lives (Nutbeam, 2006). Each level of literacy allows for greater autonomy in a person's life, and to achieve all of the different levels, one not only needs cognitive and social development, but exposure to and education on particular content (the effects of the social determinants of health and public policy, medical terms, advocacy groups, and social welfare initiatives) through a specific medium (websites, television, pamphlets, articles, videos, etc.) (Nutbeam, 2006). Nevertheless, the different levels of literacy are not seen as exclusive or hierarchical, as one can possess different levels of each of these skills (Chinn, 2011).

This hierarchy also reflects the idea that we have entered the "third wave" of health literacy, or health *system* literacy, as described by de Leeuw (2012). Such literacy is defined as possessing "the skills, capacities, and knowledge required to access, understand, and interact with social and political determinants of health and their social discourse [which] also requires a new appreciation of the political ecosystem in health promotion" (de Leeuw, 2012). This embodies the idea that each person can be seen as a health expert who is entitled to be heard and help shape the societal environment both as an individual and within a community (de Leeuw, 2012). Following from this, de Leeuw asks us to recognize that even in the modern day, political ecosystems have been dramatically changed (2012). Some from economic collapse or haphazard governmental structures, but still others as a result of the expression of genuine desire for the

public's voice to be heard (de Leeuw, 2012). The volatility of societal structures and the shifts in political elites could be seen as an opportunity for health professionals to develop all types of health literacy, as well as to cause individuals to fight for the changes they want within society to improve social justice and equity in health (de Leeuw, 2012). With this said, the final level in this hierarchy, Critical literacy, is arguably the most important due to its powerful functionality as a tool of critical education.

From this critical perspective, education must supply us with specific content so that we grow to become critical thinkers. This is not a skill we develop naturally. We must be taught to think outside the box, to challenge information we encounter, and take nothing for granted, even information from health professionals. Therefore, improvement in critical health literacy would greatly affect not only a person's health, but also their aptitude for thinking critically in regards to the current state of Canadian health, education, and public policy.

Critical health literacy can be charted and measured in a number of ways, to the discretion of the researcher. It is arguably made up of a four-step process: *knowledge*, which focuses on the teaching of the social determinants, political advocacy, and health as a human right; the *compass*, which is an activity that helps students find their own personal direction as an active agent of social and political advocacy and change, a direction which compliments their interests and skills and is aimed at achievable goals; the development of *skills*, which teaches specific advocacy skills, critical thinking tools, and specific knowledge and strategies to be used in social life; and *action*, which is the motivating, engaging, and empowering of the public towards the development of an action plan intended to address health inequalities and the social determinants (Mogford et. al, 2011). Critical health literacy can also potentially be measured across four separate dimensions: knowledge of social determinants and health disparities, attitude

towards social determinants of health and activism, empowerment to use newly developed skills to take action on the social determinants (for example, by measuring new skills developed), and future intentions to act on the social determinants (Gould et. al, 2010).

This type of critical awareness can inspire political activism and lobbying for the modification of the social determinants, especially towards healthier public policies and increased levels of government involvement (Mogford et. al, 2011; Nutbeam, 2006). Furthermore, higher scores of combined communicative and critical health literacy have been associated with better health, as well as an openness towards, acknowledgment of, and increased understanding regarding social determinants at work in society (Chinn, 2011; Snyder, 2015). If people are educated on these health-degrading factors and policies at work in society, if more noise is made about the social determinants, more change will be enacted now and in the future. Such awareness and activism can completely reshape how we approach these complex yet solvable problems in society, and hopefully eradicate them for future generations.

While critical health literacy is an exceedingly important component of health literacy, it does not receive the attention it is warranted within educational structures in Canada. Critical health literacy is a severely neglected domain of health literacy, as it is rarely focused on and rarely achieves intended outcomes (Sykes et al., 2013). This is partly due to the confusion that surrounds this concept, as no clear definition exists across the literature regarding health literacy (Sykes et al., 2013). Due to this, "any potential this concept may have to offer cannot be realised and tools to measure it accurately cannot be developed" (Sykes et al., 2013). The only way critical health literacy can be properly addressed is through a commitment from health professionals to provide information in an accessible way and to engage in shared decision-making strategies with the public (Sykes et al., 2013). This can be supplemented by political

action from the individual level through collective lobbying and activism, so that both top-down and bottom-up strategies are used to "crack the nut" of health equity from both the individual and governmental levels (Baum, 2007). Educating people on the positive health effects that result from these strategies will expose them to the problems we now face regarding health, education, and public policy, and hopefully push them to demand for the social determinants of health to be better addressed in the public sphere.

There is much to be done, however, if the critical literacy perspective is to make any impact at the individual or public level. For critical health literacy to improve, people need a familiarity with health issues and services, as well as an interest and motivation to find out more about health issues within their communities (Sykes et al., 2013). We also need to shift our educational system to teach people about skill building, and develop an understanding of health inequalities and the social determinants of health based on principles of community development and social justice (Sykes et al., 2013). There also needs to be an increased amount of political recognition regarding the importance of health literacy, as well as both the drive and a supply of resources from the governmental level (Sykes et al., 2013).

The multitude of benefits that can be gained from improvements in health literacy, and specifically critical health literacy, are too numerous to list completely. Some such consequences resulting from improvements in critical health literacy include: an increase of self-determination in regards to health, improved quality of life, improved health behaviour outcomes, more effective and efficient use of health services, increased social capital, improved understanding and questioning of the forces that enable and determine health inequalities, and increased social and political activism and change (Chinn, 2011; Sykes et al., 2013). The public must be made aware of this oppression, as well as how it is determined and maintained (Chinn, 2011; Polakow,

1985; Sykes et al., 2013). Only then will people fight to change the structure and nature of society. This is why education on the effects of public policy and the social determinants of health is so critical for health promotion initiatives and improving the health of society at large. As it has been said, "before you can kill the monster you have to say its name" (Pratchett, 2015). Therefore, if the public does not realize there is a problem, or if they do not properly understand what is truly causing a problem, no social or political activism will be undertaken, and nothing will be done.

Improving Education and the Social Determinants of Health

It is easy to see how education, and specifically health literacy, is the foundation for the development of numerous other social determinants of health, and different levels of early childhood care, experiences, and education are arguably the most important determinants of adult health. Proper levels of cognitive development and education are fundamental determinants of health, as (for example) a 30-year-old white man with less than 9 years of education can expect to live an average of 10 fewer years than a white man of the same age who graduated from high school (Fiscella/Kitzman, 2009). Less education is associated with the earlier onset of chronic diseases, disability, and declining functional status within society (Fiscella/Kitzman, 2009). These problems begin to form even before we are born and continue to affect us throughout our lives. Therefore, action should be taken to educate children as early and as much as possible about these health influencing factors, especially the effects of the social determinants of health, to avoid the development of future preventable health problems.

The environment we experience as children, and even prior to our birth, sets us on specific pathways towards specific levels of education, health, and well-being throughout the life

course. The environment children experience in utero is influenced by maternal socioeconomic status, low levels of which are related to the development of adult disease risks and a vast assortment of other health problems (Lynch et al., 1997). Lower-income families are statistically more likely to be less educated, and a person's education determines everything from how knowledgeable they are in regards to proper nutrition, to how well they determine risk factors inside and outside the medical realm, as well as to what degree they are able to understand a doctor's instructions (Ungar, 2005). Being poorly educated negatively affects development, health, level of literacy, and socioeconomic status. Health literacy levels have been found to be associated with education, poverty, employment, having a first language other than the national mother-tongue, and the deprivation of area of residence (Rowlands et. al, 2017). Low health literacy skills have also been linked to an increased risk for long-term, life-limiting health behaviours and conditions, and increased overall mortality (Rowlands et. al, 2017).

People in lower socioeconomic situations also have limited options available to them when attempting to make health-conscious decisions in the society they operate within. People born into families that are poor are far less likely to eat proper amounts of fruits, vegetables, carotene, and vitamin C, as well as being more likely to consume higher amounts of salts, coffee, and other addictive and unhealthy substances due to financial constraints or a lack of education (Lynch et al., 1997). Additionally, children who come from higher-income families, have at least a high school education, and work in higher-quality jobs, are more likely to own their home, have more material possessions, and experience lower rates of financial and job insecurity, unemployment, work-related injury, disability, and early retirement (Lynch et al., 1997). Children who are poorly educated would have lower levels of all types of health literacy, putting them at risk of developing further health problems resulting from issues regarding the

communication and understanding of health advice. Children in lower-income families also suffer more detrimental determinants of health at every stage of their lives, putting them at a higher risk of developing debilitating health problems, experiencing severe poverty, and dying prematurely.

Limited resources prior to and after birth stunt development, making it harder for those who suffer such ailments to acquire and maintain a higher-quality job, reducing their income, and further harming their health. Furthermore, children with poor parents experience up to 10 times higher rates of psychological dispositions such as hopelessness, depression, and cynical hostility as adults, making it even more difficult for people who suffer from such disorders to pursue and secure adequate employment or education (Lynch et al., 1997). Those who only have a primary education earn an average of less than half the mean income in society; are 3 times more likely to not own their own home and report low levels of financial security; are 20 times more likely to have been unemployed in the last 5 years; and are upwards of 250% more likely to be injured on the job (Lynch et al., 1997). These effects make it exceedingly difficult for people who find themselves in these deprived situations to properly address and improve their health at every stage of their lives.

Detrimental living conditions not only influence the health of children, but also sets the foundation for the development of health problems such as type II diabetes, cardiovascular disease, and other diseases on into adulthood (Raphael, 2012). Additionally, health beliefs and behaviours developed in childhood have been found to continue on into adulthood, setting the stage for future adult health (Kenny, 2012; Kenny/Moore, 2013). Furthermore, it has been found that students and adults with a higher SES are more likely to possess and understand content related to the social determinants of health, as well as increased levels of general knowledge

(Kenny/Moore, 2013). Education level also helps to determine health status by impacting future job possibilities, income level, level of critical thinking skills, and neighbourhood of residence (Chinn, 2011; Fiscella/Kitzman, 2009). Educating children sets them on a pathway for experiencing positive social determinants of health throughout their lives, and provides them with the tools for properly combating most negative social determinants of health they may experience in their lives.

The current educational curriculum in Canada, however, is quite devoid of social determinants of health content, focusing on the "trinity" of risk instead (Gould et. al, 2010; Kenny/Moore, 2013). Public secondary school is often the last opportunity for many people to learn about health within the educational system free of cost (at least within Canada), and yet it still operates under curricular standards developed in 1999 and 2000, which explain its archaic teaching methods and the areas which receive the most attention and funding within education (Kenny, 2012). Current youth descriptions of the connections between social determinants and health outcomes are often vague and disjointed, suggesting a lack of clear understanding (Kenny/Moore, 2013). It should not be surprising, then, that it is often the case within secondary school that the only health-related course which is mandatory as a prerequisite to graduate is grade 9 "Healthy Active Living Education" (or some derivative of this phrase), which focuses on the topics of behaviour, personal lifestyle factors, diet, exercise, social skills, conflict resolution, and safe sex practices, with little or no mandatory inclusion of social determinants information within the health curriculum (Kenny/Moore, 2013). Safe sex is seen as more important in adolescent education than the fact that income and policies can limit a person's individual potential in a multitude of ways. Even so, exposure to social determinants of health content is arguably most beneficial to adolescents, as they possess a high learning capacity, malleable

brain, can start to understand difficult concepts, have yet to establish many foundational health habits, and can use the information gained to help them make better choices in all areas of life (Kenny/Moore, 2013).

Only 2 out of the 13 courses within health offered to seniors discuss personal *and* social factors which influence health not only at the individual level, but at the communal and environmental levels as well (Kenny, 2012). Most courses focus on promoting the value and maintenance of physically active lifestyles, understanding the physical and biological movements of the body, and building leadership skills through physical activity endeavours (Kenny, 2012). Even those initiatives which acknowledge and work with the importance of healthy educational practices and public policies continue to place a much greater importance on individualistic and lifestyle factors (Kenny, 2012).

Teaching of the social determinants is also limited, suggesting that even teachers and administrative professionals have a lack of adequate understanding regarding these topics, which is needed if they are to regard them as important and to feel comfortable teaching them within their classes (Kenny, 2012). Thus, we must re-educate the educators with new and innovative teaching styles, while ensuring they are aware of the philosophies such as the Freirean educational concepts contained in this work and elsewhere. Additionally, we must work to reduce the lack of relevant literature and research on youth perceptions of health, endeavours which could be extremely useful in identifying gaps in knowledge and determining the most productive teaching methods, as well as identifying which information should be included in the curriculum (Kenny/Moore, 2013).

Most research on health literacy is also focused more on adults than youth, and often even equates the concept of adult health literacy with youth health literacy (Bröder et al., 2017).

Rothman et al. proposes, however, that there are four categories which are unique to youth health literacy: developmental changes, dependency on resources and skills, epidemiological differences, and vulnerability to social-demographical determinants of health (2009). Additionally, while most definitions of health literacy across the literature recognized both individual attributes and contextual factors, most still placed more emphasis on individual action and responsibility regarding health (Bröder et al., 2017). This not only downplays contextual factors, but also limits the problem of health to the capacity and competency of individuals (Bröder et al., 2017). This focus on individual factors and action is reminiscent of the lifestyle perspective on health, which focuses on these same individual aspects. As such, the preferred outcome of most health literacy-based strategies is "healthier behaviours", where healthy equates to conformity to what is considered healthy by current health professionals, experts, and society, with little critical thinking (Bröder et al., 2017). Health literacy is more than merely action or a collection of skills. It involves the contextual environment which may or may not allow people to act on these skills and other such opportunities for empowerment (Bröder et al., 2017). Health literacy must be viewed in the context that it takes place within and the social practices within which it is performed (Bröder et al., 2017). Consequently, the needs of health literacy far exceed the health care setting, as they involve personal empowerment and are intertwined with broader determinants of health (Bröder et al., 2017). Individualistic-understandings of health literacy may do very little to achieve public health literacy goals or improve the equitable distribution of the resources, content, and knowledge related to the social determinants of health (Bröder et al., 2017).

The lack of social determinants content in education and research is also not surprising, as there is little overarching institutional support for such research or for teaching the social

determinants in schools. Most of the institutions that train and fund professionals and students, the governmental bodies which set educational standards at the provincial and federal levels, and the industries which give direction to the fields of public health, research, and education, all focus on individual health behaviours (Gould et. al, 2010). To change such a structure will not be easy, but it is not impossible. Arguably, we owe it to ourselves and humanity to attempt to improve society where we can. Attempting such change is debatably better than having our situation remain the way it is, allowing so many preventable social problems to go unsolved.

To counteract this, improved education in these critical areas must take place both inside and outside the medical, health, and educational institutions (Kenny/Moore, 2013). Knowledge, then, is extremely important for health as it helps to condition our social environment (Kenny, 2012). Children who are better educated, and have higher levels of health literacy, will arguably develop better, and go on to acquire a better education, better jobs, and as a result, enjoy better health as adults. The opposite can be said of those families who receive a limited income or improper education for their children, and as a result, they will be at a higher risk for developing detrimental health-related problems. If people are educated on what is healthy at an earlier age, they will be more likely to make healthier decisions, even within the larger socioeconomic and political environment they find themselves in. For example, if people were educated on how to ventilate their homes better, or how to check for mold in their homes, the health of the everyday individual would be more in the hands of each individual person as opposed to the landowners, city officials, regulatory bodies, and construction workers responsible for the condition of their housing situation (WHO, 2010).

By educating people on how to eat properly and how to effectively prevent disease, they would be more likely to make more well-informed, health-conscious decisions throughout their

lives. Furthermore, by educating people on the effects of eating healthy, exercising properly, and adopting healthy public policies, governments can ensure an increased level of health and productivity for all of their citizens (Pati et al., 2012). This method can also be applied to being educated on the true effects of public policy and the social determinants on health, as being knowledgeable in these areas would naturally allow people to make healthier decisions in relation to these social factors.

If the public is not made aware of the effects of the social determinants of health, public and social policy activities that improve the social determinants will be less positively received by voters, and this is a fact that policy makers and the rest of the political realm must be wary of and act on in the future (Raphael, 2012). Teaching the public about these effects can be handled by public health units in the same way and with the same level of effectiveness that they achieved in teaching the public about the importance of not smoking, exercising properly, and following a healthy diet (Raphael, 2012). Social determinants of health information can also easily be incorporated into courses related to social studies, history, health, politics, law, and governmental features (Gould et., al, 2010). If we begin to educate young people on the idea of health as a collection of a diverse lifestyle and social factors, these ideas will take root in their young minds, and they will begin to see and hopefully fight and lobby for the political and social action that desperately needs to be undertaken to change the health-degrading policies we currently have in place within Canada.

Doing so will give parents, children, teachers, and students more control over their lives, their health, and the health of future generations. This would create a healthier world for parents and their children, improving the health of the child both before and after birth through proper nutrition, proper education, proper care, and by living in a world which has adopted health-

conscious public policies focused on the social determinants. Improving these social living conditions not only benefits those who experience them, but benefits society as a whole by improving productivity and reducing the pressures on health care need (Raphael, 2012). This explains why health literacy must be a focus of public health initiatives, ensuring that people can gain more control over their health, and that the future health care budgets are put to better use.

There are many ways we can incorporate these types of ideas inside and outside the educational curriculum within Canada using strategies that will address the philosophies, theories, and arguments I have presented thus far. These can be enacted and followed by politicians, policymakers, government officials, medical professionals, pharmaceutical representatives, educators, and health practitioners of any kind. These problems must be attacked from every angle, using interdisciplinary and multidisciplinary techniques, and utilizing multiple different methods to incorporate and respect many different learning styles, belief structures, and world views, while working to keep things fresh, innovative, and interesting (Gould et. al, 2010). We must also be sure to regularly update content and organizational structures to reflect current debates in public health, as well as help children grow up in a world of increased educational resources and awareness (Kenny, 2012).

We must use education to remind ourselves that we are not powerless. The feeling of social and political powerlessness than many feel in regards to changing their situation is a result of a combination of social risk factors usually associated with low SES, material deprivation, and low community cohesion (Kenny, 2012). The realization that we are all powerful political beings, and being taught as such through critical health literacy, can teach and encourage acts of individual activism, as well as the importance and necessity of collective action (Kenny, 2012). We must also allow for more research on the social determinants, education, and health literacy,

as policy is partially informed by research and public political perceptions, so as to address and understand these problems even better than we currently do (Kenny, 2012). There is always more to learn, especially from the multitude of subjects contained within Freire's phenomenological world.

In order for ideas related to the social determinants to gain the momentum and attention they require to change society, then, we must first address these problems in ways which use familiar language, concepts, and processes. We must link the current beliefs related to individualizing, behavioural, and lifestyle models of health and society to the social determinants framework, to link the old to the new (Gould et. al, 2010; Kenny, 2012). People need to know how to read a label at McDonald's and understand why it is unhealthy, but they also need to know why it is also cheap, filling, and ubiquitous (Chinn, 2011). People know these types of individualistic models and concepts, so we should build on what they know and link it to more comprehensive notions of health and its determinants (Gould et. al, 2010). This would also integrate Freire's idea of praxis, using old elements and new elements to construct a new and slightly familiar whole. Additionally, it would respect his philosophies on critical consciousness, knowledge, and education by addressing all factors related to health and well-being, and not simply submitting to an already established structure, information source, or authority.

To encourage the linking of upstream and downstream factors, Canadians must be aware that the social determinants of health address the problems we currently bring attention to regarding health in a way which not only helps relieve the factors related to the overvalued "trinity of risk" more than current individual-focused strategies, but also works to create a better, more educated, inclusive, and healthier society for everyone in the process. I have to believe, as others have said, that if students, teachers, and the rest of society were actually aware of and

convinced by the evidence that acting on the social determinants leads to a healthier individual and society, they would *at least* support the supplementation of current educational programs and models with critical health literacy concepts, if not support the complete structural reformation of education and possibly even society itself (Chinn, 2011; Gould et. al, 2010; Kenny, 2012).

To properly understand and support these concepts, people must be made familiar with them, as well as having them presented in a way which depicts them not as complex, difficult problems with seemingly impossible solutions, but as potentially manageable problems with achievable solutions (Kenny, 2012). If this is done, people will support initiatives which recognize the social determinants and make addressing such factors a priority, ensuring resources are being sent and put to good use within these problematic areas (Kenny, 2012). The Canadian political sphere, however, is currently unreceptive to such ideas.

There is a severe lack of institutional and governmental political will to enact such "radical" policy change regarding the social determinants of health (Kenny, 2012). Politicians and policymakers want to respond to the demands of the public, not present foreign ideas which the public have never heard of. These "radical" ideas, while evidence-based, will not secure as many votes or as much support as the common individualized, behavioural-focused approaches often seen in most political platforms and programs. As stated before, people are more likely to support and vote for what they are familiar with, and politicians who speak about the social determinants are speaking an unfamiliar dialect to most of the Canadian public. Thus, more attention and funding goes towards traditional strategies and programs, businesses start to back politicians who further their interests, and a cycle begins, keeping the social situation in Canada more or less the same year after year.

Increased education to promote awareness of the social determinants could place these concepts in the forefront of the public's mind, thereby strengthening awareness towards them among individuals and the public at large. Currently, the public understands health in terms of biomedical and behavioural factors, a view perpetuated by the biomedical dominance, neoliberal ideology, and the depoliticization of education and health. Education on the fact that these biomedical and behavioural factors are actually shaped by larger socioeconomic and political environments would arguably make people be more likely to support decisions aimed at improving the social determinants rather than focusing on addressing the effects of biomedical or behavioural factors, or even gaining profit. Demonstrating how the social determinants and public policies affect health will also help to identify the range of ways educators, politicians, policymakers, and the public can fulfill their duties to health promotion beyond that of simply regulating behaviour both inside and outside the medical setting (Kenny, 2012; Snyder, 2015). This will hopefully promote a more complex and comprehensive view of health and its determinants, while increasing support for broader, more upstream-focused initiatives to address these social problems (Snyder, 2015).

Focusing on merely the biomedical and behavioural effects related to health (such as genetics, diet, physical activity, and substance use) is merely applying a "Band-Aid" to the larger political, social, and economic problems that are actually the foundation for the development of these biomedical, behavioural, and lifestyle factors within society (Lavallee/Poole, 2009). Such initiatives treat the symptoms of these problems, not the causes. Even such, many institutions state that the public wants more prevention and wellness programs to cut down of health care costs, reinforcing individual-responsibility ideology and biomedical dominance (Snyder, 2015). Such institutions feel and say that their hands are tied, and they have to give the public what they

want. If we could change what the public wants, then, we could begin to change what would be demanded of such institutions and potentially alter many aspects of the societal structure.

Socially-oriented public health promotion with a focus on critical health literacy allows everyday people to become better educated in these complex social, political, and economic issues, and use this acquired knowledge to exert more freedom and control in regards to their own health status and their social environment (Pati et al., 2012). This is why I believe education on the effects of public policy, the social determinants, and critical health literacy on health is crucial for the adoption of healthier public policy and social welfare initiatives in the future: it is because people will be more likely to vote for an idea they have had experience with than they are to support an idea which they have never encountered, especially when being said by a politician. If people were taught about the effects of public policy and the social determinants of health at an earlier age, they would be made more familiar and sensitive to these ideas and the injustices that result from them when they become adults. These ideas would not seem so foreign to Canadians (as they currently do), and the public would be more likely to understand, accept, and lobby for policies and strategies which properly address these factors in relation to health, health literacy, education, and healthy public policy adoption.

This has the potential to reshape society from the roots. Such a plan could plant a new seed, creating new people within a new society and a restructured and more comprehensive environment of teaching, learning, social welfare, togetherness, and a respect for the true determinants of health and well-being in society. The steps I have mentioned thus far are necessary but not sufficient to reshape the whole of society, but education and health are arguably the perfect areas to begin such endeavours due to their ability to affect the rest of

society. If we want social change, there is no better place to start than how we think, learn, and teach in our own environments, as these are the mechanisms through which we shape society.

Why Do These Problems Continue to Persist?

If this is the case, coupled with the growing body of evidence that proves that the social determinants of health are primary factors in determining biomedical and behavioural conditions and socioeconomic status in society, then why is so little being done to remedy these issues? Why are such unhealthy policies continually implemented, enforced, and maintained if so many people are harmed by them? Why are the poor getting poorer and the rich getting richer, even when the former outnumber the latter? The answers to these questions are what I will now venture to explore.

Historical Materialism

One way to understand why so little attention is paid to social determinants content is to consider Marx's concept of *Historical Materialism*, as explained by Pogge. This concept explains that the perspectives and ideals of those in power are imposed on the rest of society, which then begins to shape the way the common person sees the world, even determining what they see as right, wrong, possible, or impossible (Pogge, 2008). Indeed, "it is undeniable that one's interests and situation influence what one finds morally salient (worthy of moral attention), what notions of justice and ethics one finds appealing and compelling, and which reforms one regards as available rather than utopian" (Pogge, 2008). Thus, the dominant groups in society shape what we see as worthy of our attention and funding, which endeavours seem practical, and which seem like "unreachable ideals" that are not even worthy of an attempt.

Such ideologies reinforce cultural hegemony through conformity and the spreading of and consent to the dominant powers in society (Chinn, 2011). Thus, such ideology and power can be used as an institution for social control, so that social conditions are created for a specific, oppressive purpose (Chinn, 2011). This is why students are taught to follow specific rules, to obey authority, and to behave a particular and arguably uncritical way (Chinn, 2011). In this way, hegemonic and dominant beliefs dampen critical thought by reinforcing and rewarding conformity, creating barriers to revolution and change from the very roots (Chinn, 2011). This type of structure also reinforces individualistic-based thinking, telling people that it is their own fault for their situation in life, and that if people could just "pull themselves up by the bootstraps", or just try hard enough to succeed monetarily and materially, their lot in life could be improved (Chinn, 2011). As stated, however, things are not always so simple and "clean cut".

Due to its place of authority, the dominant powers can alter many areas and levels of a society. In Canada, one of the dominating ideologies is that of capitalism. Capitalism (much like any other cultural or political disposition) influences what people believe, what they consider desirable, the focus of their ideas, the function of politics, the media, and the idea of social life (Coburn, 2010). Thus, where you grow up and what information you are fed throughout your life will shape who you are and how you operate in society.

Thus, we generally become people of our respective environments, and we create ideas that are a result of our respective environments. For example, the question of free health care for all people, irrespective of their ability to pay, is a question that is much more important to the poor than the rich, because it is a problem the rich are not faced with (Pogge, 2008). The rich, however, are the ones who have more power and influence to initiate change in society, and as such, society continues to form in favour of the rich and powerful. Clearly, then, a person's

social, political, and economic situation will affect the concrete judgments a person acquires and holds in relation to a specific set of moral views and values harvested from one's immediate environment. Due to our world being dominated by people who are interested in maximizing profit and not the overall well-being or health of humanity, these health inequalities and moral violations continue to run rampant in our world, with little hope of being remedied.

Neoliberal Ideology and Power

Another reason it is difficult to change our dispositions towards education, health, public policy, and justice is due to the dominance and power of neoliberal ideology. *Neoliberalism* asserts that free enterprise produces the proper levels of economic growth, which is seen as the basis for human well-being, and markets and "free" trade are seen as factors which improve human welfare (Coburn, 2010). Due to its position in the structure of society, then, neoliberal rationality has helped shape how health and education are defined, treated, and promoted in many areas within Canada (Ayo, 2012).

There are essentially five neoliberal principles: minimal government involvement, market fundamentalism, risk management, individual responsibility, and inevitable inequality as a consequence of free choice (Ayo, 2012). These beliefs come to be reflected in current health promotional strategies and policies, depicting the idea of the "good" or "healthy" citizen to which we should want to conform (Ayo, 2012). Astoundingly, this conformity is never done through force, but rather it is gained through governmentality and political rule so that it operates on autonomous citizens who *willingly* regulate themselves in regards to the interests of the state (Ayo, 2012). In this way, it incites the desire to choose governmental imperatives, aligning individual needs with social needs, and pushes individuals to change their own behaviour (Ayo,

2012). Such a tool could obviously be used to benefit all of humanity, or gain the maximum amount of profit through oppression, depending on where such intentions were aimed.

Health policies and promotion strategies often focus on individualistic structures of health as per the individualistic belief structure associated with neoliberalism. This has allowed the health, wellness, and fitness industries to "inoculate" an obsession with lifestyle factors related to health and wellness (Ayo, 2012). This aligns the interests of neoliberalism and health as they mutually reinforce the ideal vision of the responsible, entrepreneurial citizen who should work and live to maximize their own health through lifestyle choices (Ayo, 2012).

Even in our own society, the propaganda related to this idea of health has begotten an obsession with certain sports brands and clothes, causing new gyms to be built all over, all done to signify the public's active pursuit of lifestyle health (Ayo, 2012). This is reflected in society's current love of "fit, tight, and taut" bodies, the opposite of which is seen as disgusting and undesirable (Ayo, 2012). This also increases social value on such lifestyle beliefs and choices, causing people to feel socially excluded or become ostracized if they do not buy into such fads or support such values in their lives, forming another avenue of social control (Ayo, 2012). This is not to discredit the health benefits of physical activity, or the "organic green" or fitness industries, but only brings attention to the overrated nature of these lifestyle factors, while asking us to consider what purpose lies behind such actions: are they truly altruistic, or merely an appearance to help people hop on the next social band-wagon via neoliberal ideals (Ayo, 2012). The effects of lifestyle factors on health are consistently magnified beyond their true importance, taking attention away from the social and political mechanisms which create these health problems in the first place. Reflecting on the information contained in this paper, the current state of the health industry within Canada is an utter joke.

Regarding education, neoliberalism also favours behavioural and lifestyle understandings of health. Those in power focus the money and influence they possess to address lifestyle factors, as these are individual problems which can be solved without the need for excessive government involvement, and which produce sizeable profits through the selling of drugs, exercise equipment, and other health-related and nutritional products (Ayo, 2012). Less government involvement also means more room for the creation of new private markets and more products to feed the consumers in this profit-based societal structure (Ayo, 2012). Instead of being publicly supplied and governmentally regulated, most "experts" and corporations are currently encouraged to offer their products through the free market, where it is expected that the responsible, health conscious, and neoliberal citizen will buy into them, perpetuating the idea that citizens must consume to prevent health risks and live the "good" life (Ayo, 2012). This puts the entire burden of health and responsibility on the individual, as a need for a collective fix for health would require some form of government involvement, a notion which is against neoliberal policies (Ayo, 2012).

Freedom is another important aspect of neoliberalist ideology. The rolling back of regulation and the marketization of social life is apparently done to increase freedom and choice (De Lissovoy, 2015). This increases individual responsibility, as it is one's own fault for the choices they make in life. If the wrong choices are made, there is no one to blame but yourself. This idea of neoliberal freedom, however, is a contradiction in terms and is in fact a "profound form of capture" (De Lissovoy, 2015). This type of freedom is defined as "freedom from or lack of coercion", and thus describes freedom as a negative right (De Lissovoy, 2015). As such, it also does not rule out authoritative constraint entirely, but only that it be reduced as much as

possible, and only be used in ways which prevent more harmful forms of coercion (De Lissovoy, 2015).

Freedom, then, is not the freedom to do as one wishes, but is aligned with carefully planned out economic, political, and legal beliefs and policies, and is fundamentally suspicious of governmental bodies (De Lissovoy, 2015). This causes initiatives which call for governmental aid to consistently be ignored. Neoliberalism does not, however, wish to do away with the state, as it needs such an institution to function properly. Instead, it works to insert its own goals and values into the heart of the government and society, so that the laws and policies in place work to serve the vested interests of those in power rather than human well-being (De Lissovoy, 2015).

To justify these ideas, neoliberalism asserts that because the market *can* be used to adjust and align individual behaviours with social needs and values (thereby producing the foundation for the creation of a society), that it *should* be used to do so (De Lissovoy, 2015). This assumption, however, is guilty of the is/ought fallacy, which states that simply because something *is* some way does not necessitate that it *should* therefore be that way. There are arguably other ways to organize society, such as by focusing on social-welfare and education instead of profit, and these could be viable options for aligning individual and societal drives, if only we try them out in experimentation. If society is merely understood as a capitalist market, this will not only influence the values and beliefs people will hold, but also cause citizens to believe they can only act "properly" by competing for and accumulating capital, or by becoming capital themselves (De Lissovoy, 2015). This idea has become so embedded in our society that the purpose of one's life is often seen as merely to work, generate money, produce, consume, and accumulate (De Lissovoy, 2015).

As argued by De Lissovoy, this type of ideology has allowed neoliberalism to be blind to its own faults and contradictions by focusing on its virtue of freedom (2015). This type of freedom, however, may mean freedom to starve, to make mistakes without a social safety net, or to run mortal risk without social benefits to aid those who are vulnerable (De Lissovoy, 2015). Furthermore, the inequalities this structure creates and maintains are not only unavoidable, but arguably desirable (De Lissovoy, 2015). Such an organization of society is inviting to investors and savers, but is harsh to anyone who requires any level of social aid, and prevents the growth of and value regarding social services and benefits (De Lissovoy, 2015). This regulatory growth goes against the very concept of freedom, so that even freedom-enhancing, emancipatory, and empowerment initiatives currently only allow people to *seemingly* make a free choice, as long as it is in line with the provided options, and thus, is not true freedom (Chinn, 2011; De Lissovoy, 2015).

Additionally, there is significant evidence which supports the view that neoliberalist free-enterprise politics and the public policies that come with them actually undercut the social aspects needed to allow for a well-functioning economy (Coburn, 2010). These policies undermine equality and function on the basis of exploitation of the work force. The neoliberal structure also allows for some groups to be responded to more or less than others, as is the case with the needs of the rich and the poor (Coburn, 2010). This breeds inequalities in health and political power, as well as shifts the blame for these problems to the individual as opposed to the overarching social, political, and economic structures in place which allow these problems to occur in the first place (Coburn, 2010).

This type of neoliberal agenda is more about ideology than evidence (Labonte, 1997). The evidence constantly shows how detrimental the neoliberal structure is, and yet nothing is

done to alter it. Harmful products such as cigarettes and other carcinogens remain on the market due to their history or their demand (Labonte, 1997). If we followed the evidence instead of profit or ideology, harmful factors in our environment such as this would be banned and removed, however this seems to be an unwanted option due the massive profits harvested from these problems.

Additionally, neoliberalism views the market as the golden mechanism for the distribution of health and resources in society. In this structure, the interests of businesses are valued over the demands of individuals, allowing for more privatization and less government involvement, especially in regards to social welfare initiatives (Coburn, 2010). It is a sad fact that in our modern world, "the wants of the wealthy trump the needs of the poor" (Coburn, 2010). I believe this quote outlines this problem perfectly: notice it says the "*wants*" of the wealthy and the "*needs*" of the poor. This is because our society is more concerned with giving the rich what they *want* as opposed to supplying the poor with a baseline of resources that they *need to survive*.

Sadly, this is at least partly due to the fact that there is no profit in establishing such rights for the poor. It is expensive to attempt to supply the poor with adequate resources to ensure a baseline of health and socioeconomic standing, and few corporations or other high-income entities seem interested in supplying the money or resources to enact such initiatives. Businesses, the entities with the most money, possess influence and power to enact change in our self-made and market-centered society, but are concerned with increasing profits, not with the overall health and welfare of humanity. Thus, the dominant groups in society see the last few years and do not view them as years filled with health-related and environmental degradation, but as a time of exploding free markets and increased profits (Pogge, 2008).

This explains why those in power do so little to address these problems: not only are

these problems not being brought to their attention, but those at the top are actually benefitting

from the current structure of society. They have no need for change, as things are going

exceedingly well for them as they are. They can exploit workers, pay people less, and because

governments support free markets, the policies put in place also benefit businesses over the

individual. Why would these powerful entities ever change the structure of society and risk

losing the enormous profits they gain from such an oppressive structure (Ayo, 2012)? Without a

shift in this ideology, these health inequalities and unhealthy public policies will continue to be

implemented and severely degrade Canadian health for years to come.

Commodification: Medicalization and Knowledge

Neoliberalism asserts that goods such as health and education are commodities that only

those who can afford them should be able to enjoy. A person can only attain a proper level of

health or education if they can navigate through the market-oriented world and work hard

enough to gain enough money to purchase these commodities. As a result of neoliberal ideology,

the forces of *medicalization* and the *commodification* of knowledge have also become serious

issues in Canada. Medicalization is defined as making aspects of our reality part of the medical

realm that were not considered as such before (Barnet, 2012). This means taking aspects of our

everyday life and turning them into something worthy of biomedical attention. For example,

being a little overweight becomes obesity, and hyperactivity becomes ADHD. The designations

of "obesity" and "ADHD" are determined by the medical community, and enforced by public

policy, as policies affect our classification of diseases (Suissa, 2009). Public policy also shapes

how things such as addictions and different ways of life shift from being seen as a social

condition to a diagnosable, treatable disease or ailment (Suissa, 2009). Furthermore, the pharmaceutical and medical industries have taken the responsibility for health for themselves, and as such, they are able to determine what health is and is not, what is related to health and what is not, and how political health is determined to be (Bambra et al., 2005).

These newly medicalized aspects of society are also based on the maximization of profit. For example, obesity is no longer seen as a social condition, but something that one can pay to have both diagnosed and treated in the "proper" way through biomedical medicine. This process is beneficial to those who have a vested interest in the medical field or the pharmaceutical industry, as they continue to gain profit and exercise power over the rest of society. Increased medicalization means more problems to resolve through biomedical and behavioural treatments, further shifting the focus in regards to these problems towards the individual and away from social, political, economic, and structural factors. Essentially, health is seen as a job for doctors, not for politicians or governments. Those in power support this view, and as such, more focus is given to these perspectives than the social determinants of health. This controls what the public views as the best ways of treating these issues, as well as controlling the educational body of knowledge in regards to health, research, public policy, and education.

Through this control of what is seen as "medical", these institutions also control what we determine to be "knowledge" of health-related facts. Those in power tell us what constitutes knowledge and put policies in place which make it expensive or difficult to get into school or to access this type of critical knowledge. Knowledge and health are being made into commodities to be purchased by those who can afford them, not a right which should be available to all for the betterment of humanity.

Defining Health as Apolitical

A further reason why the problems afore mentioned seem to persist is due to the argument that health is not a political matter. Health is often purported to be outside the political realm, but there are several reasons for why this is clearly not the case. The first reason health is political is because much like any other good in a neoliberal society, some social groups have more of it than others (Bambra et al., 2005). A second reason is because the social determinants of health are "amenable to political interventions and are thereby dependant on political action" (Bambra et al., 2005). A third reason is because the right to a certain standard of living for the acquisition of adequate health and well-being is (or arguably should be) a core aspect of citizenship and a basic human right (Bambra et al., 2005). Finally, health is a political matter because power can be exercised on it as part of a much larger scale economic, social, and political structure, and any attempt to change this structure would require a great amount of political awareness and struggle (Bambra et al., 2005). For all of these reasons, health is a political matter, even if it is not generally seen as such.

Furthermore, how we understand and discuss politics and what is included in it is itself a political process (Roberts, 2016). While assessing and defining limits and possibilities for education, health, politics, or social change, the policies adopted and the actions taken by current political parties are certainly important (Roberts, 2016). Defining concepts as apolitical is itself an expression of a particular structure of beliefs and values specific to a certain individual or communal ideology (Roberts, 2016). Education and health cannot be taken out of politics, and neither can value or meaning (Maclure, 1976). This perspective of politics benefits those in power by allowing them to leave health out of discussions on political initiatives, specifically undermining and downplaying the effects of public policy and the social determinants on human

health. This allows biomedical and behavioural initiatives to gain further support and funding through their apparent superiority in regards to addressing health issues, shifting the responsibility for health to the citizens and health practitioners, and away from the political sphere where more good can be done.

How We Can Address These Problems

The way we can properly address these issues regarding the health of Canadians lies in the improvement of education, critical health literacy, and the social determinants of health. Educating people on these facts will bring about public awareness, social and political change, increased productivity and autonomy, and better health overall for Canadians. As Dennis Raphael states, if such endeavours were enacted, "hopefully, educated citizens would become engaged in the process by which public policy is made at the municipal, provincial and federal levels" (2012). This would push advocacy groups, policymakers, unions, and politicians to recognize the importance of the social determinants of health and implement initiatives to address them (Raphael, 2012). To date, public health units have not put much effort in educating the public about these factors, perhaps due to their biomedical-focused training, lack of understanding of the social determinants of health, or a reluctance to participate in activities that may be viewed as "political" (Raphael, 2012). If the public is educated on the positive effects that a social determinant-focused perspective can have on health, we can initiate the much-needed change in Canadian society in regards to health, education, and public policy.

In the absence of state support for addressing the social determinants of health within Ontario, local Public Health Units (PHUs) have begun taking action into their own hands (Raphael and Sayani, 2017). Recently, after the release of a video entitled "*Let's Start a*

Conversation About Health…and Not Talk About Health Care at All" (Sudbury and District

Health Unit, 2011), 17 of the 36 PHUs within Ontario adapted the video for their own local use

to help address social determinants at work in their areas (Raphael and Sayani, 2017). These

PHUs recognize that placing these activities within a critical health literacy framework should be

an essential component of public health promotion (Raphael and Sayani, 2017). Such action by

local PHUs has clear implications for those governmental authorities which refuse to address

these problems through state level interventions (Raphael and Sayani, 2017).

As it stands, there continues to be no explicit mandate within Canadian policy demanding

state intervention for increasing the equitable distribution of the social determinants through

public policy action (Raphael and Sayani, 2017). Research is done, some funding is given, but no

public policy change to address these issues is ever seen (Raphael and Sayani, 2017). Even the

federal government's list of public health goals makes no explicit mention of health equity or the

social determinants of health (Raphael and Sayani, 2017). As such, the addressing of these issues

falls into the hands of provincial governments and cities, entities which are ill-equipped to play

this role as they have limited control over the mechanisms that distribute social and economic

resources (Raphael and Sayani, 2017).

Despite having insufficient resources, avenues for social change, or any strong support

from governmental authorities, local PHUs in Ontario are willing and able to undertake the

activities of public policy advocacy, public education, and improvements in critical health

literacy (Raphael and Sayani, 2017). This can be done through a three-step process, whereby

PHUs increase knowledge and awareness internally, move to local areas, and progress towards

increased public policy advocacy and public education strategies (Raphael and Sayani, 2017). In

fact, this is how 9 PHUs are currently approaching the social determinants in their activities within Ontario (Raphael and Sayani, 2017).

After adopting the video, many of these PHUs are also reporting both first- and second-loop learning (Raphael and Sayani, 2017). Single-loop learning is when "individuals, groups or organizations modify their actions according to the difference between expected and obtained outcomes. In double-loop learning, the entities (individuals, groups or organization) question the values, assumptions and policies that led to the actions in the first place" (de Leeuw et. al, 2015). Following these realizations, all 17 PHUs intend to work towards performing local actions to help "crack the nut" of health equity by applying both upstream and downstream pressures for public action on the social determinants of health (Baum, 2007; Raphael and Sayani, 2017). Thus, the lack of governmental support for addressing the social determinants can be compensated by local PHUs (Raphael and Sayani, 2017), however state-level help is required for these problems to be optimally addressed.

Another such initiative to inform the public about the social determinants of health within Canada is the Saskatoon and Toronto based *Upstream* campaign. This campaign is focused on teaching the public about the social determinants, gathering and reporting evidence to this effect, as well as being dedicated to learning and building on new ways to invest wisely in the future by addressing the causes behind the causes of health problems (upstream/social determinants) instead of solely where the effects of these causes manifest themselves in society (downstream/lifestyle factors) (Upstream, 2017). Upstream uses this growing body of evidence harvested from a multitude of fields and organizations to guide recommendations for advocacy and change in society, while using many different forms of media and educational strategies to include, inform, and engage the various social and cultural groups within Canada about these

important factors regarding health (Upstream, 2017). This campaign also hopes to improve both individual and communal action and advocacy, giving each individual the opportunity to change and improve their environment, to remedy the effects of poverty, and experience their health and their autonomy to their fullest potential (Upstream, 2017). These endeavours work to bring communities together, to recognize the political power of individuals and collectives, and to bring attention to the factors which allow such preventable social and political problems to manifest and persist (Upstream, 2017). Upstream sees that addressing these factors helps everyone in society, not only those at the top, by creating a healthier social and political system for all (Upstream, 2017). This is just another example of how local initiatives in Canada are currently working to fill the role the government seems reluctant to fill in regards to education on the social determinants of health, and the subsequent addressing of such problems.

If we want to improve the health of Canada on a massive scale, education and knowledge must be made freely available to all, regardless of their socioeconomic standing, and this requires public and governmental involvement. Our education system must also be committed to teaching the public about the effects of the social determinants, and specifically how improved education and public policy adoption can influence health in *all* ways. The public must also be made aware that strategies which tackle these social problems are not quick fixes, and only with time can they be properly implemented (Maclure, 1976). Most political parties do not last the 10-15 years which are necessary to completely fulfill most socially-rooted initiatives aimed at the social determinants (Maclure, 1976). As such, the Canadian public must be made aware that political parties need the help of the public in order to actualize such endeavours over vast allotments of time.

Public policy is arguably one of the most important ways of addressing the social determinants of health. Nevertheless, we must avoid our tendency within public policy adoption to allow for the "lifestyle drift" effect to occur, whereby policy starts off recognizing the need for upstream action at the political and institutional levels regarding the social determinants of health, only to drift downstream to focus again on merely individually-based biomedical and lifestyle factors (Popay et al., 2010). Public policy currently favours businesses, who benefit from health being sold as a commodity, and who would lose capital if there was more public and governmental involvement on these issues (Popay et al., 2010). Due to this, social welfare services are constantly being redesigned to facilitate flexible labour markets, forcing many to encounter unhealthy work environments due to long hours, low pay, and scarce benefits (Popay et al., 2010). As stated above, however, meeting the needs of individuals, including their health needs, currently follows a consumerist agenda that opposes such collective and governmental approaches (Popay et al., 2010).

Therefore, if the health of Canadians is to be improved in any significant way, public health initiatives must resist lifestyle drift, educate the public on the social determinants of health and critical health literacy, reduce market-centralization, and advocate for social and political change at all levels of society affected by these factors (Popay et al., 2010). Critical health literacy, education, public policy, social awareness, and political action must all be improved if the social determinants of health are to be properly addressed within Canada.

Conclusion

Through the course of this paper, I have shown why education and critical health literacy are extremely important factors in alleviating the health problems we currently find in Canada.

This is because critical education sets people on a pathway towards improving health and well-being through awareness of the far-reaching effects of the social determinants of health. Educating people on these forces at an earlier age will allow them to become more sensitive to these emancipatory ideas, hopefully allowing these notions to work their way into the public domain the way lifestyle perspectives currently do in society, and eventually fuel the social, political, economic, and educational welfare initiatives of the future.

One way this type of reformation is possible is through the education of the public on the injustices that we allow to occur through our own complacency within society. The public needs to be shown that those in power are shaping the world around us, determining what we see as right and wrong, and what we see as viable or impractical options in regards to improving our health and our world. If we can enact this paradigm shift, more health-conscious policies will be established, and more people will fight for their implementation and continued enforcement at the individual and governmental levels. Allowing governments to act more freely in regards to their people through increased levels of government involvement will allow our health to be better addressed by focusing on the effects of public policy and the other social determinants on human health. This in itself will greatly improve our health and well-being in the years to come, and is an endeavour public health authorities cannot delay in pursuing any longer if they truly want to take the health of Canadians seriously.

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