

PRAISE FOR *SOCIAL DETERMINANTS OF HEALTH: CANADIAN PERSPECTIVES*

“[*Social Determinants of Health*] may not be light summer reading for the cottage or the beach, but it does shed a lot of light on the way we live now as Canadians. Edited by York University professor Dennis Raphael and with a thoughtful foreword by Roy Romanow, it’s a collection of research and observations by academics and leading-edge thinkers (a whole new community, in a way, formed around this issue) about how social determinants of health play out in Canadian life.

“Raphael’s book explores each of recognized social determinants that impact on health and well-being in Canada in the context of what exists ‘on the ground’—how theory translates into real life. If a book can walk the walk as well as talk the talk, this one does. It’s a significant resource for teachers, students, and researchers. But it’s also a useful, important, and eye-opening reminder for all of us about how our political and societal choices determine the health—literally, the extent of illness, disease, disability, medical costs—of Canadians.”

—Judy Gerstel, *The Toronto Star*

“This book makes a highly significant contribution to the field of Public Health in Canada. Aside from being well-researched and well-written, a major strength of the book is its focus on identifying clear policy directions to improve the health of Canadians by influencing each of the social determinants. Raphael’s book is essential reading for university students, practitioners, program managers, and policy-makers in all of the human service sectors.”

—Benita Cohen, University of Manitoba

“We finally have a Canadian book that we can refer to, in order to assist in ‘making the case’ for a population health approach. This book does not shy away from the ‘tough questions’ of politics and social policy. It’s quite hard-hitting at times. That’s a real positive.”

—Victoria Barr, University of Victoria

“The book is very accessible to general/non-specialist audiences. My students commended the book for its accessibility and coherence. This volume is straightforward, easy to read, accessible to undergraduate students. Canadian content is also hugely important.”

—Alan Davidson, University of British Columbia



SOCIAL DETERMINANTS OF HEALTH





SOCIAL DETERMINANTS OF HEALTH

CANADIAN PERSPECTIVES



SECOND EDITION

EDITED BY DENNIS RAPHAEL

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For Alexander and Toba





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FOREWORD TO THE SECOND EDITION

When Tommy Douglas brought our first universal publicly funded health system to the province of Saskatchewan, he passionately argued that medicare must not only ensure that people get the health care they need when they need it, but it must implement public policies for keeping people well, not just patching them up once they get sick.

Unfortunately, since that time medicare has been pulled toward a commitment to the service contract of health care delivery. Thankfully, in Canada we have had Dennis Raphael sounding the alarm that just focusing on the “repair shop” is not only counter to our Canadian values of social justice, it will ultimately put the sustainability of our cherished health care system at risk. His scholarship and dogged advocacy on the need to address the broadest possible approach to social determinants of health has been a powerful antidote to the “tyranny of the acute.”

It has been said that Canada led thinking on population health with the Lalonde Report of 1974, *New Perspectives on the Health of Canadians*. In 1986 the *Ottawa Charter* identified five action areas for health promotion, the fourth of which, “Building healthy public policy,” called for “complementary approaches, including legislation, fiscal measures, taxation and organizational change. Health promotion policy requires the identification of obstacles to the adoption of healthy public policies in non-health sectors and the development of ways to remove them.”

Since then, a tremendous amount of research has shown that health is influenced by a wide range of policies and interventions that go beyond health care. Interestingly, the Canadian Institute for Advanced

Research estimates that only 25 percent of the health of the population is attributable to the health care system, while 15 percent is due to biology and genetic factors, 10 percent results from the physical environment, and 50 percent is attributable to the social and economic environments. Health can no longer be the sole responsibility of the ministers of health.

Throughout this volume there is a profound sense of frustration that despite the increasing discussions and evidence on the importance of dealing with the social determinants of health, Canadian public policy-makers have been embarrassingly resistant to these concepts.

I believe that as long as citizens think of the “sickness care system” whenever they hear the word “health,” we are going to have real trouble in our efforts reorienting public policy to the social determinants of health. Surely the production of health through poverty elimination or workplace hazards reduction must fit side by side with a system mandated to operate emergency rooms and to reduce wait times for surgical services? Canadians must understand that upfront investment in the social determinants of health today will prevent larger amounts of money being spent on treatment and rehabilitation later on.

Dr. Halfan Mahler has said that “Health is politics,” and that “If you want to move healthy public policies forward, you have to have political dynamite.” SARS, Kashechewan, Hurricane Katrina, or the heat wave in France in 2004 that killed over 14,000 have been important teachable moments. I believe we have done a terrible job of explaining the “Pay now or pay a lot more later” economic arguments for investing in health of citizens. “A stitch in time saves nine,” “penny-wise

and pound foolish” are axioms we were all raised on. But the “tyranny of the acute” means that putting new drugs on the formulary and a new gamma knife for the world-class surgeon becomes the squeaky wheel and active measures on the social determinants of health take a back seat again and again. In Canada we have also suffered because the social determinants of health criss-cross many government departments and all jurisdictions. We have been unable to break through the gridlock of jurisdictional squabbles and vertical ministerial accountability for these complex challenges.

I think citizens do understand the social responsibility—health as a fundamental human need and therefore a basic human right and our moral obligation to do the right thing. But if they or a loved one are on a wait list, they expect their politicians to immediately respond and fix it. The medical model still rules.

There is no question that the political will to do the right thing dramatically improves with an educated public. Health literacy means that citizens can be pulling healthy public policy from their governments and politicians. I am a big believer in bottom-up solutions and the importance of improving the methodologies for true civic efficacy.

However, we have a formidable enemy in the sales department of modern media. Simple messages and simple solutions fit on a bumper sticker and in a seven-second sound bite. Every day I am reminded of the quote of H.L. Mencken: “For every complex human problem there is a neat simple solution, it’s just that it’s wrong.” I believe that we must fiercely defend the complex solutions for the complex problems that are facing health and health care, but I believe we have to find simpler messages, plain language if we are going to have citizens onside.

The WHO Commission on Social Determinants of Health, which is headed by Sir Michael Marmot, is examining the “social determinants of health” and “health inequities,” but he is now brilliantly talking about the causes and the “causes of the causes” that better explain the huge gaps in health outcomes.

Lately I have found that the following short health literacy quiz has been helpful in putting the public back into public health and replacing “health care” with “systems for health.”

HEALTH 101

Do you think we should have

- (a) strong fence at the top of the cliff or
- (b) state-of-the-art fleet of ambulances and paramedics waiting at the bottom?

Would you prefer

- (a) clean air or
- (b) enough puffers and respirators for all?

Would you prefer that wait times be reduced by

- (a) a falls program to reduce preventable hip fractures or
- (b) private orthopaedic hospitals and more surgeons?

Should we invest in

- (a) early learning, child care, literacy, the early identification of learning disabilities, and bullying programs or
- (b) increase the budget for young offenders’ incarceration?

Should we

- (a) assume that the grey tsunami will bankrupt our health care system or
- (b) include our aging population in the planning of strategies to keep them well?

Is the best approach to food security

- (a) food banks and vouchers or
- (b) income security, affordable housing, community gardens and community kitchens, and a national food policy?

Pick the one that is not correct:

Pandemic preparedness should focus on

- Tamiflu for all
- working with the vets to keep avian flu a disease of birds
- making sure people wash their hands, especially the doctors and nurses
- research on vaccines
- community care plans for our most vulnerable

Should governments boast about

- (a) how much they spent on the sickness care system or
- (b) the health of their citizens, leaving no one behind?

The profound structural change needed to secure investments in the social determinants of health in our complex federal system will occur only if we succeed in raising public awareness and developing political will. As you know, politicians tend to follow where the public goes, so helping the public understand the issues and demand change from governments will be crucial. For me, a major challenge in Canada is to make the public understand, believe, and take ownership that ill health, poverty, and social exclusion are unacceptable in one of the richest countries of the world. Progress toward a healthier world thus requires broad participation, sustained advocacy, and strong political action.

I firmly believe that this book provides an imperative for Canada to move from the description of the problem and the prescription of solutions to implementation of systematic and meaningful strategies and interventions to improve the health of our citizens and eliminate the inequity particularly among our First Peoples.

Population health is ultimately a question of what kind of society we wish to live in. The aim of population health is for human health to be seen as one of the most important overall objectives of public policy.

This is about advocacy, leadership, and action. It is about the civic literacy of putting health back into health care. Dennis Raphael has articulated a vision.

The other contributors have shown us that real solutions are out there in trenches. We need the political will to harvest those solutions into better public policy across government departments and across the squabbling jurisdictions.

I was there that Friday night in November 2002 at York University in Toronto for the opening of the conference “Social Determinants of Health across the Lifespan.” I remember hearing John Frank and Dennis Raphael speaking so passionately about these things that seem so sensible and doable.

This book updates the progress to date in the scholarship and evidence of the interventions that can improve the overall health of the population and reduce health disparities, which will allow tens of thousands, and maybe even millions, of Canadians to lead longer lives in better health. This, in turn, will result in increased productivity because a healthy population is a major contributor to a vibrant economy, reduced expenditures on health and social problems, and overall social stability and well-being for Canadians. Perhaps even more importantly, a focus on interventions to deal with the social determinants of health will translate into a fairer and more equitable society.

Disraeli said that “The care of the public health is the first duty of a statesman.” Unfortunately, in our present political system, statesmen, as defined by James Freeman Clarke, are rare: “A politician thinks of the next election, a statesman the next generation.” If this book were compulsory reading for all elected officials and public servants, we could achieve not only a healthier, more equitable society but also the added dividend of more statesmen!

—Dr. Carolyn Bennett, MP, FCFP; assistant professor, Department of Family and Community Medicine, University of Toronto; Canada’s first minister of state for public health, 2003–2006



FOREWORD TO THE FIRST EDITION

One of the key points that I made in *Building on Values: The Future of Health Care in Canada* is that we have to set a national goal of making Canadians the healthiest people possible. One of the keys to achieving this goal is a greater emphasis on preventative health measures and improving population health outcomes.

Although I referenced this in my report, I will be the first to admit that even if all of my 47 recommendations are adopted, and even if they are implemented the way I would want them to be, it will only take us partway toward this goal.

A health care system—even the best health care system in the world—will be only one of the ingredients that determine whether your life will be long or short, healthy or sick, full of fulfillment, or empty with despair.

If we want Canadians to be the healthiest people in the world, we have to connect all of the dots that will take us there. To connect the dots, we have to know where they are. Those who have contributed to this volume have added valuable perspectives in this regard as they connect research and ideas on the social determinants of health to the health outcomes we seek as a nation.

Healthy lifestyle choices may be important and vital—and they are. A comprehensive, responsive, and accountable national health care system may be important and vital—and it is.

But the main factors—the main “determinants,” as the experts call them—that will likely shape our health and lifespan are the ones that affect society as a whole. And if we want Canadians to be the healthiest people in the world, we have to deal with them at that level.

The editor of this text, Dr. Raphael, has gathered together some of Canada’s important thinkers on the key

determinants. This volume provides the latest research and ideas regarding income distribution; the importance of a healthy workplace; the critical role that early childhood education, and public education generally, plays in the life-cycle process; the importance of food and shelter; and the importance of belonging reinforced by various views of social inclusion.

I noted recently that our policy-making and program-developing mechanisms in Canada are suffering from what I call “hardening of the categories.” Something useful is proffered by one government department with the intended gains stifled by something counterproductive in another department.

Our policy-making processes need to be integrated and integrating. We need to move from an illness model to a wellness paradigm that connects the dots of all of the factors that contribute to health for individuals and society at large.

Even if we make great strides to improve our systems of health care in Canada, our genuine gains in health will be hindered unless we pay serious attention to the other determinants of health. At present, there are too many children going to school and to bed hungry, too many people living on our urban streets, an increasing number of working poor, and too many people feeling like they are on the outside looking in when it comes to decision making in our communities.

How important is it that we think in new ways?

Historians and health experts tell us that we have had two great revolutions in the course of public health. The first was the control of infectious diseases, notwithstanding our current challenges. The second was the battle against non-communicable diseases.

The third great revolution is about moving from an illness model to all of those things that both prevent illness and promote a holistic sense of well-being.

In my view, the wellness model needs to be informed:

- by inspired leaders who genuinely share power with those less fortunate
- by a commitment to social inclusion and civil society that provides opportunities for all Canadians to participate in the things that count in our neighbourhoods across this great country

- by an understanding that hopelessness kills and hopefulness with opportunity is a prescription for good health

That's my kind of revolution. It's the kind that will ensure that Canadians are the healthiest people we can be. It's also the kind of revolution that understands that the exceptional health we seek, and how we achieve it, can provide a Canadian model for the world to emulate.

Social Determinants of Health provides a rich companion to our work on health care and a useful springboard for integrated healthy public policy.

—The Honourable Roy J. Romanow, PC
Saskatoon
February 2004



PREFACE

This volume updates and extends the analysis of the state of various social determinants of health in Canada contained in the 1st edition of *Social Determinants of Health: Canadian Perspectives*. This work represents a unique undertaking in the social determinants of health area as it brings together scholarship by those working in early childhood education and care, education and literacy, employment and working conditions, food security, gender, health services, housing, income and its distribution, social exclusion, the social safety net, and unemployment and job insecurity with work by those specifically focused on the health effects of these issues.

The 1st edition of *Social Determinants of Health: Canadian Perspectives* aimed to foster communication between those concerned with the current state of various social determinants of health and those knowledgeable about their health effects. Clearly the work contributed to this goal. The close to 8,000 copies of the work sold reached a wide range of sectors both inside and outside of academia. It contributed to the increasing diffusion of the social determinants of health concept into discussion of a wide range of issues. It is now common to find mention of the health-related effects of lack of child care, continuing income, housing, and food insecurity, inadequate social and health services, and other social determinants of health in a wide range of documents, reports, and related advocacy efforts.

The social determinants of health concept has been taken up by pioneering public health units across Canada striving to shift the discussion of health away from biomedical and behavioural risks toward emphasizing living conditions as the primary determinants of individual and population health. United Ways of Canada, Social Planning Councils, and numerous other agencies concerned with striving to improve the quality of life of

Canadians now draw upon the social determinants of health concept in their activities.

Yet for all of this increased discussion of the social determinants of health concept, there is precious little to show of its effects upon the development of public policy in Canada. There is little evidence that policy-makers draw upon these concepts and related research findings to create health-promoting public policy. Media coverage of health issues continues to be dominated by biomedical and behavioural approaches and, not surprisingly, public understandings of the determinants of health mirror these preoccupations. Clearly there is a continuing need to present the social determinants of health message.

The 2nd edition continues to raise these issues. There is greater attention paid to the ideological barriers to having these issues addressed by those working in the health field and the makers of public policy. In addition to the updating of the material presented in the chapter, new or newly authored chapters focus on:

- the pathways and mechanisms that explain how social determinants of health come to shape health
- early childhood and how a range of factors shape children's health
- the complexity of Aboriginal health and its determinants
- the health care system and how it serves as a social determinant of health
- public policy and the social safety net
- public policy and gender

As before, the aim of *Social Determinants of Health: Canadian Perspectives* is to promote more accurate public understandings and more mature public policy-making

in the support of health. These have clearly proven to be difficult tasks to accomplish in Canada. This has not been the case in many other nations. It is reassuring, though frustrating, to note that the social determinants of health concept has taken root and been nurtured in many

European nations such that public policy in the service of health is increasingly common. Hopefully, this volume will help to narrow the gap between Canadian action on the social determinants of health and those seen in other nations.

—Dennis Raphael
August 2008





A NOTE FROM THE PUBLISHER

Thank you for selecting the 2nd edition of *Social Determinants of Health: Canadian Perspectives*, edited by Dennis Raphael. The editor, contributors, and publisher have devoted considerable time and careful development (including meticulous peer reviews) to this book. We appreciate your recognition of this effort and accomplishment.

This volume distinguishes itself on the market in many ways. One key feature is the book's well-written and comprehensive part openers, which help to make the

chapter all the more accessible to both general readers and undergraduate students. The part openers add cohesion to the section and to the whole book. The themes of the book are very clearly presented in these section openers.

Each chapter contains the following structure: a formal introduction and conclusion, critical thinking questions, annotated recommended readings, annotated related Web sites, as well as references, which are consolidated at the back of the book.

Part One

INTRODUCING THE SOCIAL DETERMINANTS OF HEALTH



There is increasing recognition that the mainsprings of health are to be found in the manner in which societies are organized and resources distributed among the population. The concept of the social determinants of health is an illustration of how thinking is moving beyond a medical model and lifestyle approaches to understanding health and the means by which it can be maintained. In the medical model of health, the body is seen as a machine that is either running well or in need of repair. If the body is free of illness, the person is healthy. If it is either infected with pathogens or afflicted with system- or organ-malfunctioning disease, illness occurs. The remedy for such disease and illness is found in medical or curative care, which is located in the health care system and administered by doctors and nurses.

In the lifestyle model of health, the causes of disease are to be found in individuals' "unhealthy choices," such as diets lacking in fruits and vegetables, sedentary behaviours, or partaking of alcohol or tobacco. The remedy for these poor choices are health education, exhortations for individuals to change their behaviours, and even environmental adjustments (e.g., sin taxes, smoking and alcohol bans, etc.) to make the "healthy choice, the easy choice." Despite an extensive body of evidence that indicates that biomedical and behavioural indicators are rather poor indicators of health status as compared to the living conditions individuals experience, allocation of government spending to the health care system, research activities, and disease foundations reflect strong commitment to the medical and lifestyle approaches to health. The preoccupation of the public, the media, and governments with the medical and lifestyle approaches to health ensures that broader concerns with living conditions usually receive less attention.

In Chapter 1, **Dennis Raphael** defines and identifies the social determinants of health. He provides a brief history of the concept and an overview of Canadian evidence that indicates that living conditions—rather than biomedical and lifestyle indicators—related to the distribution of income, the provision of housing and food security, and the security of employment and quality of working conditions are the primary determinants of health. These social determinants of health help to explain how improvements in health status among Canadians over the past century came about, why there are important differences in health status among Canadians, and why Canadians are healthier than Americans, but less healthy than citizens of the nations of northern Europe. Raphael then identifies some key emerging themes that help inform the content of the chapters that follow.

In Chapter 2, **Dennis Raphael** discusses the latest research on how the social determinants of health come to be related to the health of individuals, communities, and entire jurisdictions. The chapter considers a variety of models of how living conditions come to "get under the skin" to shape health. These models include what are called materialist, psychosocial comparison, and neo-materialist approaches. How the social determinants of health influence health are also assessed by applying models of physiological and psychological processes that examine how the social determinants of health shape health. To understand how inequalities in the quality of the social determinants of healthy people experience come about and how these unequal experiences come to influence health, models of political economy are presented that identify the economic and political forces that shape these unequal distributions of social determinants.

Chapter 1

SOCIAL DETERMINANTS OF HEALTH: AN OVERVIEW OF KEY ISSUES AND THEMES

Dennis Raphael

Introduction

Social determinants of health are the economic and social conditions that shape the health of individuals, communities, and jurisdictions as a whole. Social determinants of health are the primary determinants of whether individuals stay healthy or become ill (a narrow definition of health). Social determinants of health also determine the extent to which a person possesses the physical, social, and personal resources to identify and achieve personal aspirations, satisfy needs, and cope with the environment (a broader definition of health). Social determinants of health are about the quantity and quality of a variety of resources that a society makes available to its members.

These resources include, but are not limited to, conditions of childhood, income, availability and quality of education, food, housing, employment, working conditions, and health and social services. An emphasis upon societal conditions as determinants of health contrasts with the traditional health sciences and public health focus upon biomedical and behavioural risk factors such as cholesterol levels, body weight, physical activity, diet, and tobacco and alcohol use. Since a social determinants of health approach sees the mainsprings of health as being how a society organizes and distributes economic and social resources, it directs attention to economic and social policies as means of improving it. It also requires consideration of the political, economic, and social forces that shape policy decisions.

Concern with the social determinants of health is not new. It has been known since the mid-19th century that living conditions are the primary determinants of health (Engels, 1845/1987; Virchow, 1848/1985). And since then hundreds of studies have demonstrated that the material and social circumstances to which people in developed nations such as Canada are exposed to in their homes, workplaces, and communities are far more important to their health than so-called “lifestyle choices” such as using tobacco or alcohol, eating fruits and vegetables, or partaking in physical activity (Nettleton, 1997; Tesh, 1990). These findings have not been lost upon the writers of Canadian government and public health documents. Since the mid-1970s Canadian governmental and public health agencies have produced numerous statements and policy documents that have contributed to health promotion efforts worldwide. In large part, Canada’s reputation as a “health-promotion powerhouse” comes from the high quality of the concepts and ideas contained within these documents (O’Neill, Pederson, Dupéré & Rootman, 2007).

Nevertheless, even a cursory examination of prevailing governmental and public health activities focused on actually promoting health—as opposed to documents talking about promoting health—sees little evidence that applications of these concepts have been made in practice (Raphael, 2007a). The profound gap between Canadian health promotion word and deed is documented (Canadian Population Health Initiative,

2002). Instead of efforts to improve Canadians' living conditions, individualized approaches focused on biomedical and behavioural risk factors—with some exceptions—dominate governmental, public health, disease association, and other health-promotion efforts (Raphael & Bryant, 2006b).

When living conditions are considered by these health authorities, it is usually to identify those Canadians whose living conditions are said to put them at risk for making “unhealthy lifestyle choices” rather than urging governmental authorities to improve their living circumstances. Rather than improving the primary determinants of health—the adverse living conditions people are subjected to—activities focus on targeting the victims of these adverse living conditions for behaviour change. This is the case even though health behaviours are known to be rather less important determinants of health. The effect of all this is to add insult—victim blaming—to injury—the experience of deprived living conditions (Raphael, 2002).

Not surprisingly, public understandings of the determinants of health mirror these activities (Canadian Population Health Initiative, 2004). Surveys show that Canadians have little awareness of the important role that living conditions play in determining health (Eyles et al., 2001; Paisley, Midgett, Brunetti & Tomasik, 2001). The mass media reinforces these understandings through its uncritical reporting of any and all studies of how a particular gene or behaviour (e.g., drinking coffee or white wine, eating peanuts, consuming tomatoes, sleeping more than or less than eight hours a night, watching too much TV, or playing computer games, etc.) either protects from, or predicts, some dire medical condition (Gasher et al., 2007; Hayes et al., 2007).

That these findings may be weak and contradictory to findings reported a week or two earlier does little to slow these reporting onslaughts (Davey Smith & Ebrahim, 2001). Therefore, this volume has two rather daunting tasks: (1) to counter the understandings Canadians hold concerning the determinants of health; and (2) to provide support for efforts to improve the quality of the social determinants of health through the development of health-promoting public policies.

In this chapter, I review the social determinants of health concept and present recent theoretical developments and empirical findings. I provide the

rationale for selecting the social determinants of health included in the volume and explore a number of key themes in the field. Throughout this presentation the social determinants of health approach is contrasted with the traditional approach to disease prevention focused on biomedical and behavioural risk factors. I conclude by asking the reader to consider how Canadians' understandings concerning the determinants of health and current Canadian policy environments affect both the quality of these social determinants of Canadians' health and Canadian policy-makers' receptivity to the ideas contained within this volume.

An Historical Perspective on the Social Determinants of Health

During the mid-1800s political economist Friedrich Engels studied how poor housing, clothing, diet, and lack of sanitation led directly to the infections and diseases associated with early death among working people in England. Engels identified material living conditions, day-to-day stress, and the adoption of health-threatening behaviours as the primary contributors to social class differences in health (Engels, 1845/1987).

All conceivable evils are heaped upon the poor.... They are given damp dwellings, cellar dens that are not waterproof from below or garrets that leak from above.... They are supplied bad, tattered, or rotten clothing, adulterated and indigestible food. They are exposed to the most exciting changes of mental condition, the most violent vibrations between hope and fear.... They are deprived of all enjoyments except sexual indulgence and drunkenness and are worked every day to the point of complete exhaustion of their mental and physical energies.... (Engels, 1845/1987, p. 129)

Around the same time, Rudolf Virchow (1848/1985) identified how health-threatening living conditions were rooted in public policy-making and emphasized the role that politics played in promoting health and preventing disease (see Box 1.1) These issues never completely disappeared from public health preoccupations, but over

Box 1.1: Rudolf Virchow and the social determinants of health

German physician Rudolf Virchow's (1821–1902) medical discoveries were so extensive that he is known as the “Father of Modern Pathology.” But he was also a trailblazer in identifying how societal policies determine health. In 1848, Virchow was sent by the Berlin authorities to investigate the epidemic of typhus in Upper Silesia. His *Report on the Typhus epidemic prevailing in Upper Silesia* argued that lack of democracy, feudalism, and unfair tax policies in the province were the primary determinants of the inhabitants' poor living conditions, inadequate diet, and poor hygiene that fuelled the epidemic.

Virchow stated that *Disease is not something personal and special, but only a manifestation of life under modified (pathological) conditions. Arguing Medicine is a social science and politics is nothing else but medicine on a large scale*, Virchow drew the direct links between social conditions and health. He argued that improved health required recognition that: *If medicine is to fulfil her great task, then she must enter the political and social life. Do we not always find the diseases of the populace traceable to defects in society?* (Virchow, 1848/1985).

The authorities were not happy with the report and Virchow was relieved of his government position. But he continued his pathology research within university settings and went on to a parallel career as a member of Berlin City Council and the Prussian Diet, where he focused on public health issues consistent with his Upper Silesia report. Virchow also bitterly opposed Otto Von Bismarck's plans for national rearmament and was challenged to a duel by said gentleman. Virchow declined participation.

the past 30 years have received rather less emphases than biomedical and behavioural approaches to health promotion and disease prevention (Raphael, 2001a).

British Contributions

The 1980 publication of the Black Report and the 1992 publication of the *Health Divide* (Townsend et al., 1992) sparked interest in how social conditions shape health. These UK reports described how lowest employment-level groups showed a greater likelihood of suffering from a wide range of diseases and dying prematurely from illness or injury at every stage of the life cycle. Additionally, health differences occurred in a step-wise progression across the socio-economic range with professionals having the best health and manual labourers the worst. Skilled workers' health was midway between the extremes. These health differences emerged even though the UK had developed a universally accessible health care system at the end of the Second World War. These two reports—and the many that have followed up on these themes—stimulated the study of health inequalities, and the factors that determine these inequalities and directed attention to the role that public policy plays in either increasing or reducing health inequalities (Acheson, 1998; Benzeval, Judge

& Whitehead, 1995; Gordon, Shaw, Dorling & Davey Smith, 1999; Pantazis & Gordon, 2000).

Health inequalities and the social determinants of these inequalities continue as active areas of inquiry among British researchers (Benzeval et al., 1995; Gordon, 2000; Graham, 2004a; Shaw, Dorling, Gordon & Smith, 1999). These studies frequently focus on inequalities in health among members of different employment strata with recognition that membership in such groups is strongly correlated with income and education levels. British researchers also study the health effects of poverty and how indicators of disadvantage cluster together (Gordon & Townsend, 2000; Pantazis, Gordon & Levitas, 2006). Much of the available data on the links between social determinants of health and health status are British, as are some of the best theorizations of how these factors influence health across the lifespan. The UK is also the source of many ideas on how to apply these findings to promote health (Benzeval et al., 1995; Graham, 2004b).

Canadian Contributions

Canadians have actively theorized the relationship between economic and social conditions and health. In 1974 the federal government's *A New Perspective*

on the Health of Canadians identified human biology, environment, lifestyle, and health care organization as determinants of health (Lalonde, 1974). The document was important in outlining determinants of health outside of the health care system.

Another Canadian government document, *Achieving Health for All: A Framework for Health Promotion*, outlined reducing inequities between income groups as an important goal of government policy (Epp, 1986). This would be accomplished by implementing policies in support of health in the areas of income security, employment, education, housing, business, agriculture, transportation, justice, and technology, among others. Health Canada's *Taking Action on Population Health: A Position Paper for Health Promotion and Programs Branch Staff* states that:

There is strong evidence indicating that factors outside the health care system significantly affect health. These "determinants of health" include income and social status, social support networks, education, employment and working conditions, physical environments, social environments, biology and genetic endowment, personal health practices and coping skills, healthy child development, health services, gender and culture. (Health Canada, 1998, p. 1)

Canadian Public Health Association (CPHA) documents tell a similar story. In 1986, its *Action Statement for Health Promotion in Canada* identified advocating for healthy public policies as the single best strategy to affect the determinants of health (Canadian Public Health Association, 1996). Priority actions included reducing inequalities in income and wealth, and strengthening communities through local alliances to change unhealthy living conditions. In 2000, the CPHA endorsed an action plan that recognized poverty's profound influence upon health and identified means to reduce it (Canadian Public Health Association, 2000). Other CPHA reports document the health effects of unemployment, income insecurity, homelessness, and general economic conditions (Canadian Public Health Association, 2001).

The study of the social determinants of health therefore deals with two key problems:

1. What are the societal factors (e.g., income, education, employment conditions, etc.) that shape health and help explain health inequalities?
2. What are the societal forces (e.g., economic, social, and political) that shape the quality of these societal factors?

The next section presents various frameworks for considering the social determinants of health.

What Exactly Are the Social Determinants of Health?

The term "social determinants of health" appears to have grown out of researchers' attempts to identify the specific exposures by which members of different socio-economic groups come to experience varying levels of health status. While it was well documented that individuals in various socio-economic groups experienced differing health outcomes, the specific factors and means by which these factors led to illness remained to be identified.

The term "social determinants of health" made its debut in the 1996 volume *Health and Social Organization: Towards a Health Policy for the 21st Century* (Blane, Brunner & Wilkinson, 1996). In the chapter "Social Determinants of Health: The Sociobiological Translation," Tarlov took the environment health field from the Lalonde Report—the others being biology and genes, health care, and lifestyle—and fleshed out these environmental determinants of health (Tarlov, 1996). In his model, inequalities in the quality of social determinants of housing, education, social acceptance, employment, and income become translated into disease-related processes through individuals comparing themselves unfavourably to others. The World Health Organization followed this work up with its *Social Determinants of Health: The Solid Facts* document (Wilkinson & Marmot, 2003).

The relevance of the social determinants of health was also indicated by attempts to explain how nations come to differ in overall population health. As one illustration, the health of Americans compares poorly to the health of citizens in most other industrialized nations (Raphael, 2007b). This is the case for life expectancy, infant mortality, and death by childhood injury despite the US's overall greater wealth. In contrast, the population health

of Sweden is generally superior to most other nations (Burstrom, Diderichsen, Ostlin & Ostergren, 2002). Could the same social determinants of health that explain health differences *within* national populations explain health differences seen *among* national populations? And why would nations differ so much in terms of the quality of the social determinants of health experienced by their citizens?

Current Concepts of the Social Determinants of Health

There are a variety of contemporary approaches to social determinants of health. The commonalities among these are particularly illuminative.

The *Ottawa Charter for Health Promotion* identifies the “prerequisites for health” as peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice, and equity (World Health Organization, 1986). These prerequisites of health are concerned with structural aspects of society and the organization and distribution of economic and social resources. In 1992, Dahlgren and Whitehead formulated their rainbow model of health determinants, in which the “living and working conditions” arch identified agriculture and food production, education, work environment, unemployment, water and sanitation, health care services, and housing as contributors to health (Dahlgren & Whitehead, 1992).

Health Canada outlines various determinants of health—many of which are social determinants—of income and social status, social support networks, education, employment and working conditions, physical and social environments, biology and genetic endowment, personal health practices and coping skills, healthy child development, health services, gender, and culture (Health Canada, 1998). These determinants were adapted from work done by the Canadian Institute for Advanced Research (Evans, Barer & Marmor, 1994). Within this framework, the specific concepts of physical and social environments can be criticized for lacking grounding in concrete experiences of people’s lives and lacking policy relevance—i.e., there usually is no Ministry of Physical Environments or Ministry of Social Environments. There is also evidence that these terms have little meaning for Canadians and for policy-makers (Bryant et al., 2004).

A British working group charged with specifying the social determinants of health identified the social [class health] gradient, stress, early life, social exclusion, work, unemployment, social support, addiction, food, and transport (Wilkinson & Marmot, 2003). This listing is more grounded in the everyday experience of people’s lives and policy-making structures and avoids the potential problem of policy irrelevance. Indeed, the stimulus for this work was the European Office of the World Health Organization aiming to raise these issues among policy-makers and the public. Finally, the US Centers for Disease Control and Prevention highlights social determinants of health of socio-economic status, transportation, housing, access to services, discrimination by social grouping (e.g., race, gender, or class), and social or environmental stressors (Centers for Disease Control and Prevention, 2006).

Origins of the Canadian Social Determinants of Health Conference and This Volume

As I became more familiar with the social determinants of health field, my surprise grew at Canada’s shortcomings in researching and addressing these important issues. As noted, numerous studies indicated that various social determinants of health have far greater influence on health and the incidence of illness than traditional biomedical and behavioural risk factors. Additionally, scholarship on the state and quality of various social determinants of health in Canada had been finding their quality to be deteriorating (Federation of Canadian Municipalities, 1999, 2001, 2003, 2004a, 2004b). Yet for the most part, policy-makers, the media, and the general public remained badly informed concerning these issues. Indeed, it appears at times—especially during the retrenchments in public policy that began during the late 1980s—that much of the public policy agenda seems designed to threaten rather than support the health of Canadians by weakening the quality of many social determinants of health (Raphael, 2001d; Raphael & Bryant, 2006a).

These concerns about the neglect of the social determinants of health led to my applying (through York University’s School of Health Policy and Management) to Health Canada’s Policy Research Program for funding

to organize a national conference entitled “Social Determinants of Health across the Lifespan: A Current Accounting and Policy Implications.” The purpose of the conference was to: (1) consider the state of several key social determinants of health across Canada; (2) explore the implications of these conditions for the health of Canadians; and (3) outline policy directions to strengthen these social determinants of health. The York University “Social Determinants of Health across the Lifespan” conference was organized around a synthesis that identified 12 key social determinants of health especially relevant to Canadians (see Box 1.2). Four criteria were used to identify these social determinants of health.

The first criterion was that the social determinant be consistent with most existing formulations of the social determinants of health and associated with an existing empirical literature as to its relevance to health. *All these social determinants of health are important to the health of Canadians.*

The second criterion was that the social determinant of health be consistent with lay/public understandings of the factors that influence health and well-being. This was ascertained through assessment of available empirical work on Canadians’ understandings of what aspects of Canadian life contribute to health and well-being. *All these social determinants of health are understandable to Canadians.*

The third criterion was that the social determinant of health be clearly aligned with existing governmental structures and policy frameworks (e.g., ministries of education, housing, labour, Native affairs, women’s issues, etc.). *All these social determinants of health have clear policy relevance to Canadian decision makers and citizens.*

The fourth criterion was that the social determinant of health be an area of either active governmental policy activity (e.g., health care services, education) or policy inactivity that have provoked sustained criticism (e.g., food security, housing, social safety net, etc.). *All these social determinants of health are especially timely and relevant.*

The inclusion of health services, the social safety net, and Aboriginal status as social determinants of health is not common to most conceptualizations. Health services are included in the belief that a well-organized and rationalized health care system could be an important

social determinant of health—if this is not currently the case. The social safety net is increasingly recognized as an important determinant of the health of populations, but to date has not been explicitly included in most formulations. Aboriginal status is another social determinant of health that is not explicitly explored in most conceptualizations of the social determinants of health. It represents the interaction of culture, public policy, and the mechanisms by which systematic exclusion from participation in Canadian life profoundly affects health. Gender and how its meaning is constructed within Canadian society is an important social determinant of health. It interacts with all other social determinants of health to influence the health and well-being of Canadians.

As a result of that conference, the profile of the social determinants of health was raised across Canada. One outcome was the 1st edition of *Social Determinants of Health: Canadian Perspectives* (Raphael, 2004). The second was the drafting and ratification of the *Toronto Charter on the Social Determinants of Health* (Raphael, Bryant & Curry-Stevens, 2004). The third was the establishment of a “Social Determinants of Health” listserv based at York University in Canada. Five years have passed since the 1st edition appeared and new insights have arisen concerning the social determinants of health and the barriers to their influencing public policy

Box 1.2: The social determinants of health framework

The 12 social determinants of health identified by the organizers of the York University conference form the basis for the content of this volume. These are:

- Aboriginal status
- early life
- education
- employment and working conditions
- food security
- gender
- health care services
- housing
- income and its distribution
- social safety net
- social exclusion
- unemployment and employment security

in the service of health. This volume updates and expands upon the findings presented in that volume and provides some of these insights.

Current Themes in the Social Determinants of Health Field

Five themes inform the presentation and understanding of the material in this volume: (1) empirical evidence concerning the social determinants of health; (2) mechanisms and pathways by which social determinants of health influence health; (3) the importance of a life-course perspective; (4) the role that policy environments play in determining the quality of the social determinants of health within jurisdictions; and (5) the role that political ideology plays in shaping state and societal receptivity to social determinants of health concepts. Each is considered in turn.

Theme 1: Empirical Evidence of the Importance of the Social Determinants of Health

Much of this volume is concerned with presenting the empirical evidence of how social determinants of health shape health. From an overall perspective, the quality of various social determinants of health to which citizens are exposed provides explanations for: (1) improvement in health status among Canadians over the past 100 years; (2) persistent differences in health status among Canadians; and (3) differences in overall health status among Canada and other developed nations.

The Social Determinants of Improved Health among Canadians Since 1900

Profound improvements in health status have occurred in industrialized nations such as Canada since 1900. It has been hypothesized that access to improved medical care is responsible for these differences, but best estimates are that only 10–15 percent of increased longevity since 1900 is due to improved health care (McKinlay & McKinlay, 1987). As one illustration, the advent of vaccines and medical treatments are usually held responsible for the profound declines in mortality from infectious diseases in Canada since 1900. But by the time vaccines for diseases such as measles, influenza, and polio and treatments for scarlet fever, typhoid, and diphtheria appeared, dramatic declines in mortality had already occurred.

Improvements in behaviour (e.g., reductions in tobacco use, changes in diet, etc.) have also been hypothesized as responsible for improved longevity, but most analysts conclude that improvements in health are due to the improving material conditions of everyday life experienced by Canadians since 1900 (McKeown, 1976; McKeown & Record, 1975). These improvements occurred in the areas of early childhood, education, food processing and availability, health and social services, housing, employment security and working conditions, and every other social determinant of health. Much of the current volume is concerned with the present state of these social determinants of health and how they shape the health status of Canadians. Particularly important is the question of how recent policy decisions are either improving or weakening the quality of these social determinants of health.

The Social Determinants of Health Inequalities among Canadians

Despite dramatic improvements in health in general, significant inequalities in health among Canadians persist (Health Canada, 1999; Wilkins, Berthelot & Ng, 2002). Access to essential medical procedures is guaranteed by medicare in Canada. Nevertheless, access issues are common and this is particularly the case with regard to required prescription medicines where income is a strong determinant of such access (Raphael, 2007d). It is believed, however, that health care issues account for a relatively small proportion of health status differences among Canadians (Siddiqi & Hertzman, 2007). As for differences in health behaviours (e.g., tobacco and alcohol use, diet, and physical activity), studies from as early as the mid-1970s—reinforced by many more studies since then—find their impact upon health to be less important than social determinants of health such as income and others examined in this volume (Raphael, 2007a).

Evidence indicates that health differences among Canadians result primarily from experiences of qualitatively different environments associated with the social determinants of health. As just one example, an overview of the magnitude of differences in health that are related to the social determinant of health of income is provided. Income is especially important as it serves as a marker of different experiences with many social determinants of health (Raphael, Macdonald et al., 2004).

Income is a determinant of health in itself, but it is also a determinant of the quality of early life, education, employment and working conditions, and food security. Income also is a determinant of the quality of housing, need for a social safety net, the experience of social exclusion, and the experience of unemployment and employment insecurity across the lifespan. Also, a key aspect of Aboriginal life and the experience of women in Canada is their greater likelihood of living under conditions of low income (Raphael, 2007e).

Income is a prime determinant of Canadians' premature years of life lost and premature mortality from

a range of diseases (see Box 1.3). Numerous studies indicate that income levels during early childhood, adolescence, and adulthood are all independent predictors of who develops and eventually succumbs to disease (Davey Smith, 2003).

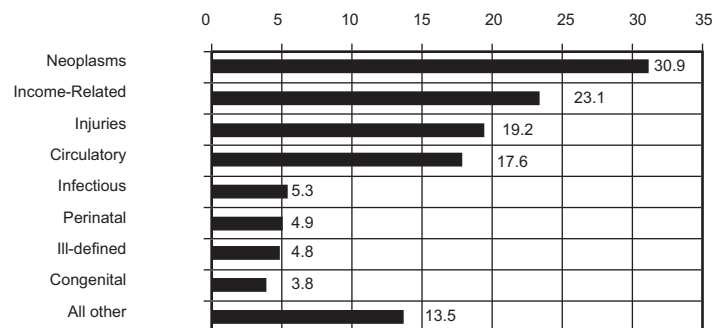
This is also the case in Canada. Income is an exceedingly good predictor of incidence and mortality from a variety of diseases. About 23 percent of excess premature years of life lost can be attributed to income differences among Canadians (see Figure 1.1). The figure of 23 percent in Figure 1.1 is calculated by using the mortality rates in the wealthiest quintile

Box 1.3: Statistics Canada study of income-related premature mortality

In Canada, data on individuals' income and social status are not routinely collected at death, so national examination of the relationship between income and mortality from various diseases uses census tract of residence to estimate individuals' income. There is potential for error in these analyses that relate income to death based on residential area, since some low income people live in well-off neighbourhoods and vice versa. Essentially, these analyses are conservative estimates of the relationship between income level and death rates. The most recent available data shows that in 1996, Canadians living within the poorest 20% of urban neighbourhoods were more likely to die from cardiovascular disease, cancer, diabetes, and respiratory diseases—among other diseases—than other Canadians (Wilkins et al., 2002).

Figure 1.1 shows the percentage of premature years of life lost in urban Canada than can be attributed to various diseases and to income differences. Cancers are the leading cause of premature years of life lost accounting for 31% of these. Injuries and circulatory diseases (heart disease and stroke) are also leading causes of premature years of life lost. However, the percentage of premature years of life lost that can be attributed to income differences among Canadians is also very high at 23%, a magnitude that is greater than all years lost to either injuries or circulatory disease and approaching the level of cancers.

Figure 1.1: Percentage of premature years of life lost (0–74 years) to Canadians in urban Canada due to various causes, 1996



Source: "Percentage of premature years of life lost (0–74 yrs) to Canadians in urban Canada due to various causes, 1996," adapted from the Statistics Canada publication "Health reports—supplement," Catalogue 82-003, Volume 13, 2002 Annual Report, Chart 9, p. 54.

of neighbourhoods as a baseline and considering all deaths above that rate to be “excess” related to income differences. Therefore, 23 percent of all of the premature years of life lost to Canadians can be accounted for by differences among wealthy, middle- and low-income Canadians (Wilkins et al., 2002).

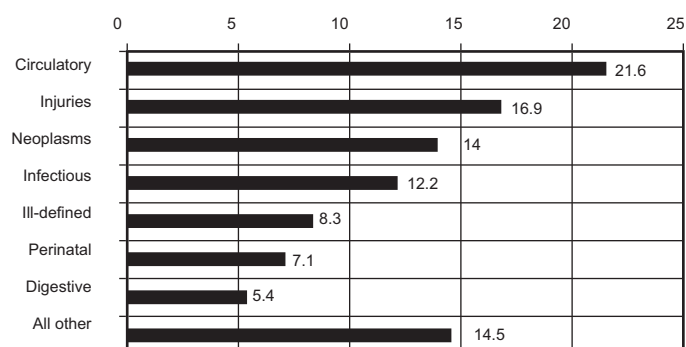
What are the diseases that differentially kill people of varying income levels? Income-related premature years of life lost are focused upon specific diseases. As shown in Figure 1.2, the diseases most related to income differences in mortality among Canadians are heart disease and stroke. Importantly, premature death by injuries, cancers, infectious disease, and others are all strongly related to income differences among Canadians.

In 2002, Statistics Canada examined the predictors of life expectancy, disability-free life expectancy, and the presence of fair or poor health among residents of 136 regions across Canada (Shields & Tremblay, 2002). The predictors employed included socio-demographic factors (the proportion of Aboriginal population, the proportion of visible minority population, the unemployment rate, population size, percentage of population aged 65 or over, average income, and average number of years of schooling). Also considered in the analysis were the daily smoking rate, obesity rate, infrequent exercise rate, heavy drinking rate, high stress rate, and depression rate. Table 1.1 shows the proportion of variation (the total is

100 percent) in health outcomes explained by each of these predictors. Consistent with most other research, behavioural risk factors are rather weak predictors of health status as compared to socio-economic and demographic measures of which income is a major component (Diez-Roux, Link & Northridge, 2000; Lantz et al., 1998; Roux, Merkin & Arnett, 2001).

These differences in premature mortality are mirrored in the greater incidence of just about every affliction that Canadians experience. This is especially the case for chronic diseases such as heart disease and stroke, diabetes, cancers, as well as injuries and infectious diseases (Wilkins et al., 2002). Indeed, the incidence of, and mortality from, heart disease and stroke, and adult-onset of type 2 diabetes are especially good examples of the importance of the social determinants of health (Raphael, Anstice & Raine, 2003; Raphael & Farrell, 2002). While governments, medical researchers, and public health workers emphasize traditional adult risk factors (e.g., cholesterol levels, diet, physical inactivity, and tobacco and alcohol use), it is well established that these are relatively poor predictors of heart disease, stroke, and type 2 diabetes rates among populations. The factors making a difference are living under conditions of material deprivation as children and adults, stress associated with such conditions, and the adoption of health-threatening behaviours as means of coping with these difficult circumstances. In fact, difficult

Figure 1.2: Percentage of income-related premature years of life lost (0–74 yrs) caused by specific diseases in urban Canada, 1996



Source: “Percentage of income-related premature years of life lost (0–74 yrs) caused by specific diseases in urban Canada, 1996,” adapted from the Statistics Canada publication “Health reports—supplement,” Catalogue 82-003, Volume 13, 2002 Annual Report, Chart 10, p. 54.

Table 1.1: Proportion of variation in life expectancy, disability-free life expectancy, and proportion of citizens reporting fair or poor health explained by different factors at the health region level in Canada (total variation for each outcome measure = 100%)

Predictors	Life expectancy	Disability-free life expectancy	Fair or poor health
Socio-demographic factors only	56%	32%	25%
<i>Additional variation predicted by:</i>			
Daily smoking rate	8%	6%	4%
Obesity rate	1%	5%	10%
Infrequent exercise rate	0%	3%	0%
Heavy drinking rate	1%	3%	1%
High stress rate	0%	0%	1%
Depression rate	0%	8%	9%

Source: Shields, M. and Tremblay, S. (2002), "The health of Canada's communities," *Health reports—supplement 13* (July), p. 13.

living circumstances during childhood are especially good predictors of these diseases (Barker, Osmond & Simmonds, 1989; Davey Smith & Hart, 2002; Eriksson et al., 1999).

In addition to predicting adult incidence and death from disease, income differences—and the other social determinants of health related to income—are also related to the health of Canadian children and youth. Canadian children living in low-income families are more likely to experience greater incidence of a variety of illnesses, hospital stays, accidental injuries, mental health problems, lower school achievement and early dropout, family violence and child abuse, among others (Canadian Institute on Children's Health, 2000). In fact, low-income children show higher incidences of just about any health-, social-, or education-related problem however defined. These differences in problem incidence occur across the income range, but are most concentrated among low-income children (Ross & Roberts, 1999; Ross, Roberts & Scott, 2000).

The Social Determinants of Health Differences between Nations

Profound differences in overall health status exist between developed and developing nations. Much of this has to do with the lack of the basic necessities of

life (food, water, sanitation, primary health care, etc.) common to developing nations. Yet among developed nations such as Canada, less profound but still highly significant differences in health status indicators such as life expectancy, infant mortality, incidence of disease, and death from injuries exist. An excellent example is comparison of health status differences and the hypothesized social determinants of these health status differences among Canada, the United States, and Sweden.

Table 1.2 shows how Canada, the US, and Sweden fare on a number of social determinants of health and indicators of population health. Scholarship has noted that the US takes an especially *laissez-faire* approach to providing various forms of security (employment, food, income, and housing) and health and social services, while Sweden's welfare state makes extraordinary efforts to provide security and services (Burstrom et al., 2002; Raphael & Bryant, 2006b). The sources of these differences in public policy appear to be in differing commitments to citizen support informed by the political ideologies of governing parties within each nation (Bambra, 2004; Navarro & Shi, 2002).

Emerging scholarship is specifically focused on how national approaches to security provision to citizens

Table 1.2: USA, Canada, and Sweden rankings on selected social determinants of health and indicators of population health in comparison to other industrialized nations (2000–2002)

(Ranking, 1 is best)			
Measure	USA	Canada	Sweden
% in child poverty	22 of 23	17	1
Income inequality	18 of 21	13	3
% in low-paid employment	24 of 24	20	1
Public social expenditure	24 of 28	23	1
Public share health spending	28 of 29	23	1
Life expectancy	20 of 26	5	4
Infant mortality	24 of 30	16	1
Child injury mortality	23 of 26	18	1

Source: Raphael, D. (2003). "A society in decline: the social, economic, and political determinants of health inequalities in the USA," in Hofrichter, R. (Ed.), *Health and social justice: A reader on politics, ideology, and inequity in the distribution of disease*. San Francisco: Jossey Bass/Wiley, 59–88.

influence health by shaping the quality of numerous social determinants of health. Nations such as Sweden, whose policies reduce unemployment, minimize income and wealth inequality, and address numerous social determinants of health, show evidence of improved population health using indicators such as infant mortality and life expectancy (Diderichsen, Whitehead, Burstrom & Aberg, 2001). At the other end, nations with minimal commitments to such efforts such as the United States show rather worse indicators of population health (Raphael, 2000).

Theme 2: Mechanisms and Pathways by Which Social Determinants of Health Influence Health

To secure the policy relevance of the social determinants of health and build support for their strengthening, it is important to understand how social determinants of health come to influence health and cause disease. Recent theoretical thinking considers how social determinants of health “get under the skin” to influence health. The Black and the *Health Divide* Reports considered two primary mechanisms for understanding health inequalities: cultural/behavioural and materialist/structuralist (Townsend, Davidson & Whitehead, 1992).

The cultural/behavioural explanation was that individuals’ behavioural choices (e.g., tobacco and alcohol use, diet, physical inactivity, etc.) were responsible for their developing and dying from a variety of diseases. Both the Black and the *Health Divide* Reports, however, showed that behavioural choices are heavily structured by one’s material conditions of life. And—consistent with mounting evidence—these behavioural risk factors account for a relatively small proportion of variation in the incidence and death from various diseases. The materialist/structuralist explanation emphasizes the material conditions under which people live. These conditions include the availability of resources to access the amenities of life, working conditions, and the quality of available food and housing, among others.

The author of the *Health Divide* Report concluded: “The weight of evidence continues to point to explanations which suggest that socio-economic circumstances play the major part in subsequent health differences.” Despite this conclusion and increasing evidence in favour of this view, much of the Canadian public discourse on health and disease remains focused on “lifestyle” approaches to disease prevention. The *Traditional Ten Tips for Better Health* reflects this lifestyle orientation while the *Social*

Box 1.4: Which tips for better health are consistent with research evidence?

The messages given to the public by governments, health associations, and health workers are heavily influenced by the ways in which health issues are understood. Contrast the two sets of messages provided below. The first set is individually-oriented and assumes individuals can control the factors that determine their health. The second set is societally oriented and assumes the most important determinants of health are beyond the control of most individuals. Which set of tips is most consistent with the available evidence on the determinants of health?

The traditional ten tips for better health

1. Don't smoke. If you can, stop. If you can't, cut down.
2. Follow a balanced diet with plenty of fruit and vegetables.
3. Keep physically active.
4. Manage stress by, for example, talking things through and making time to relax.
5. If you drink alcohol, do so in moderation.
6. Cover up in the sun, and protect children from sunburn.
7. Practice safer sex.
8. Take up cancer screening opportunities.
9. Be safe on the roads: follow the Highway Code.
10. Learn the First Aid ABCs: airways, breathing, circulation. (Donaldson, 1999)

The social determinants ten tips for better health

1. Don't be poor. If you can, stop. If you can't, try not to be poor for long.
2. Don't have poor parents.
3. Own a car.
4. Don't work in a stressful, low paid manual job.
5. Don't live in damp, low quality housing.
6. Be able to afford to go on a foreign holiday and sunbathe.
7. Practice not losing your job and don't become unemployed.
8. Take up all benefits you are entitled to, if you are unemployed, retired or sick or disabled.
9. Don't live next to a busy major road or near a polluting factory.
10. Learn how to fill in the complex housing benefit/asylum application forms before you become homeless and destitute. (Gordon, 1999; personal communication)

Determinants of Health Ten Tips for Better Health is consistent with more advanced thinking (see Box 1.4).

These conceptualizations have been refined such that analysis is now focused upon three frameworks by which social determinants of health come to influence health (Bartley, 2003). These frameworks are: (1) materialist; (2) neo-materialist; and (3) psychosocial comparison. The materialist explanation is about how living conditions—and the social determinants of health that constitute these living conditions—shape health. The neo-materialist explanation extends the materialist analysis by asking

how these living conditions come about. The psychosocial comparison explanation considers whether we compare ourselves to others and how these comparisons affect our health and well-being.

To anticipate these analyses, evidence strongly supports materialist and neo-materialist explanations for understanding how the social determinants of health come to influence health status. Chapter 2 is devoted to these and other frameworks that identify mechanisms and pathways by which the social determinants of health shape health status.

Theme 3: The Importance of a Life-Course Perspective

Traditional approaches to health and disease prevention have a distinctly non-historical emphasis. Usually adults and, increasingly, adolescents and youth are urged to adopt “healthy lifestyles” as a means of preventing the development of chronic diseases such as heart disease and diabetes, among others (Chronic Disease Prevention Alliance of Canada, 2003; Health Canada, 2003). In contrast to these approaches, life-course approaches emphasize the accumulated effects of experience across the lifespan in understanding the maintenance of health and the onset of disease. It has been argued that:

The prevailing aetiological model for adult disease which emphasizes adult risk factors, particularly aspects of adult life style, has been challenged in recent years by research that has shown that poor growth and development and adverse early environmental conditions are associated with an increased risk of adult chronic disease. (Kuh & Ben-Shilmo, 1997, p. 3)

More specifically, it is apparent that the economic and social conditions—the social determinants of health—under which individuals live their lives have a cumulative effect upon the probability of developing any number of diseases. This has been repeatedly demonstrated in longitudinal studies—the US National Longitudinal Survey, the West of Scotland Collaborative Study, Norwegian and Finnish linked data—that follow individuals across their lives (Blane, 1999). This has been most clearly demonstrated in the case of heart disease and stroke (Raphael & Farrell, 2002). And most recently, studies into the childhood and adulthood antecedents of adult-onset diabetes show how adverse economic and social conditions across the lifespan predispose individuals to this disorder (Raphael et al., 2003).

A recent volume brings together some of the important work concerning the importance of a life-course perspective for understanding the importance of social determinants (Davey Smith, 2003). Adopting a life-course perspective directs attention to how social determinants of health operate at every level of development—early

childhood, childhood, adolescence, and adulthood—to both immediately influence health as well as provide the basis for health or illness during later stages of life. These issues are considered further in Chapter 2.

Theme 4: The Role of Public Policy and Policy Environments

Much social determinants of health research simply focuses on determining the relationship between a social determinant of health and health status, so a researcher may document that lower income is associated with adverse health outcomes among parents and their children. Or a researcher may demonstrate that food insecurity is related to poor health status among parents and children, as is living in crowded housing, and so on. This is termed a depoliticized approach as it says little about how these poor-quality social determinants of health come about (Raphael & Bryant, 2002).

Social determinants of health do not exist in a vacuum. Their quality and availability to the population are usually a result of public policy decisions made by governing authorities. As one example, consider the social determinant of health of early life. Early life is shaped by availability of sufficient material resources that assure adequate educational opportunities, food, and housing among others. Much of this has to do with the employment security and the quality of working conditions and wages. The availability of quality, regulated child care is an especially important policy option in support of early life (Esping-Andersen, 2002). These are not issues that usually come under individual control. A policy-oriented approach places such findings within a broader policy context.

Yet it is not uncommon to see governmental and other authorities individualize these issues. Governments may choose to understand early life as being primarily about parents’ behaviours toward their children. They then focus upon promoting better parenting, assist in having parents read to their children, or urge schools to foster exercise among children rather than raising the amount of financial or housing resources available to families. Indeed, for every social determinant of health, an individualized manifestation of each is available. There is little evidence to suggest the efficacy of such approaches in improving the health status of those most

vulnerable to illness in the absence of efforts to modify their adverse living conditions (Raphael, 2001c).

An important purpose of this volume, therefore, is to place the social determinants of health within a public policy perspective and to outline policy options for strengthening these social determinants of health. Since evidence indicates that strengthening these social determinants of health would improve the health status of Canadians, it would be expected that governments would be responsive to these ideas. This may not be the case.

In fact, Canada has fallen behind countries such as the United Kingdom and Sweden and even some jurisdictions in the United States in applying the population health knowledge base that has been largely developed in Canada (Canadian Population Health Initiative, 2002, p. 1).

Canada's performance in implementing social determinants-relevant policy reflects a weakening commitment to supporting its citizenry. Canadian political economist Gary Teeple argues that a strong national Canadian identity and a willingness to reduce class conflict at the end of the Second World War led to the development of a strong Canadian welfare state (Teeple, 2000). The strengthened Canadian welfare state became associated with more equitable distribution of income and wealth through social, economic, and political reforms. These reforms included progressive tax structures, social programs, and governmental structures that supported health. These are the mainsprings of strong social determinants of health.

Yet, since the early 1970s—and coincident with increasing economic globalization—a fundamental change has occurred in national and global economies. In Canada, governments have weakened the structures associated with the welfare state. Federal program spending as a percentage of GDP is close to 1950s levels, and government policies have increased income and wealth inequalities, created crises in housing and food security, and increased the precariousness of employment (Raphael, 2001b). This has not been the case in all developed nations. What role does politics and political ideology play in these developments?

Theme 5: Politics, Political Ideology, and the Social Determinants of Health

Considering the evidence of the importance of the social determinants of health, how can we explain why certain nations take up this information and apply it in the formulation of public policy while others do not? Another way of considering this issue is inquire as to why there is such a gap between knowledge and action on the social determinants of health in Canada.

One way to think about this is to consider the idea of the welfare state and the political ideologies that shape its form in Canada and elsewhere. The concept of the welfare state is about the extent to which governments or the state use their power to provide citizens with the means to live secure and satisfying lives. Every developed nation has some form of the welfare state. Important questions are: (1) How developed is this welfare state? and (2) What are the implications of the welfare state for the social determinants of health?

Two literatures inform this analysis. The first concerns the three forms of the modern welfare state. Esping-Andersen identifies three distinct clusters of welfare regimes among wealthy developed nations: Social democratic (e.g., Sweden, Norway, Denmark, and Finland), liberal (the US, the UK, Canada, and Ireland), and conservative (France, Germany, Netherlands, and Belgium, among others) (Esping-Andersen, 1990, 1999). There is high government intervention and strong welfare systems in the social democratic countries and rather less in the liberal. Conservative nations fall midway between these others in service provision and citizen supports.

Social democratic nations have very well-developed welfare states that provide a wide range of universal and generous benefits. They expend more of national wealth for supports and services. They are proactive in developing labour, family-friendly, and gender equity-supporting policies. Liberal nations spend rather less on supports and services. They offer modest universal transfers and modest social-insurance plans. Benefits are provided primarily through means-tested assistance whereby these benefits are provided only to the least well-off. How do these forms of the welfare state come about? How do they shape the social determinants of health?

Navarro and colleagues provide empirical support for the hypotheses that the social determinants of health

and health status outcomes are of higher quality in the social democratic rather than the liberal nations (Navarro, 2004; Navarro et al., 2004). Some of these indicators are spending on supports and services, equitable distribution of income, and wealth and availability of services in support of families and individuals. Health indicators include life expectancy and infant mortality.

Could this general approach to welfare provision shape Canadian receptivity to the concepts developed in this volume? And, if so, what can be done to improve receptivity to and implementation of these concepts? The final chapter of this volume revisits these issues.

Developments Since the 1st Edition of This Volume

There have been some notable developments in the social determinants of health field since the appearance of the 1st edition of this volume in 2004. Internationally, the World Health Organization's establishment of an International Commission on the Social Determinants of Health has stimulated discussion (World Health Organization, 2004). To date the commission has produced excellent background papers on the social determinants of health and has begun to produce numerous final reports dealing with a range of important issues (Irwin & Scali, 2007). Two of the commission's knowledge networks (Globalization and Health and Early Childhood Development) are centred in Canada, and another (Workplace Health) has significant Canadian representation. The concept has enjoyed increased mention in the international academic literature and reviews are available (Graham, 2004a, 2004b; Raphael, 2006). The Canadian Senate's Subcommittee on Population Health has undertaken a review of the social determinants of health (Canadian Senate, 2007).

Within Canada, a few Canadian health units have distinguished themselves by their work in raising the importance of the social determinants of health (Raphael, 2007d). And there is clear evidence that those working in specific social determinants of health concept areas such as employment security and working conditions, early childhood education and care, housing, income, and food security, health and social services, and poverty reduction are more aware of how their issues impact health. Non-

governmental agencies such as the United Ways across Canada and the United Nations Association of Canada have drawn upon the social determinants of health concept to advance their work (United Way of Greater Toronto & Canadian Council on Social Development, 2002; United Way of Ottawa, 2003; United Way of Winnipeg, 2003).

While it is clear that the social determinants of health concept has attained a greater visibility among these varied sectors, there is little evidence that the concept has significantly contributed to any Canadian public policy advances in the service of health. When governments have produced health-enhancing public policies such as new housing programs or enhanced early childhood education programs, it is difficult to discern if health considerations have been considered in their decisions. There has not been the case elsewhere where social determinants of health concepts have been actively incorporated into the making of public policy (Mackenbach & Bakker, 2002).

For the most part, the social determinants of health concept within the Canadian public health scene has been limited to the production of even more policy documents declaring its importance with rather little to show for the effort. This may be a result of governing parties' political ideologies shaping policy-makers' receptiveness to the social determinants of health concept (Raphael & Bryant, 2006a). Government policy-makers will hesitate to advocate public policies that are seen as inconsistent with the views of the elected representatives who effectively serve as their employer. Identifying how these barriers may be overcome constitutes an important goal of this volume.

Conclusion

As noted, a social determinants of health approach is not a wholly new development, but has its roots in critical examination of the causes of illness and disease that date from the mid-19th century. The modern resurgence of interest into how living conditions shape health dates from the 1970s. British researchers investigated the sources of health inequalities and contributed much to our conceptual and empirical understanding of these issues. At the same time, and continuing to the present,

Canadians developed health promotion and population health concepts that directed attention to various social determinants of health. But, unlike the British and others, Canada has lagged well behind other jurisdictions in applying this knowledge to developing economic and social policies in support of health.

The pages to follow contain assessments of the current state of 12 key social determinants of health in Canada and analyses of how these conditions affect the health of Canadians. As you read each chapter, reflect upon your own life situation and the others around you in relation to the specific social determinant of health. Are you and others experiencing a higher quality of this social determinant of health or a lower quality of it? Do you see the situation improving or declining?

Consider how the quality of these social determinants of health is influenced by decisions made by Canadian policy-makers in Ottawa, your province, and your local municipality. As you read the policy options that are provided for improving both the state of these determinants and the health of Canadians, keep in mind the importance of the broader political, economic, and social environments in which Canadians are now living. To what extent do these environments influence the quality of the social determinants of health and policy-makers' receptivity to these ideas on promoting the health of Canadians? What can be done to put these ideas into practice? How can these ideas be implemented to improve the quality of the social determinants of health and improve the overall health of Canadians?

Critical Thinking Questions

1. Reflect upon the degree of familiarity you had with the idea of living conditions as primary determinants of health prior to reading the chapter. When you thought of health and its determinants, what did you think of?
2. Were living conditions and the public policies that shape them considered as health issues in your previous studies?
3. What do your answers say about how health issues are framed in Canada in general and by governments, public health agencies, and the media?
4. What does it say about your previous studies in the health sciences or related fields?
5. Look at a few days' worth of health-related stories in *The Globe and Mail* or your local newspaper. How often is there a social determinants of health angle on a health story?
6. Why do you think the social determinants of health appear to be so low on just about everybody's agenda?

Recommended Readings

Bartley, M. (2003). *Health inequality: An introduction to concepts, theories, and methods*. Cambridge: Polity Press.

Large differences in life expectancy exist between the most privileged and the most disadvantaged social groups in industrial societies. This book assists in understanding the four most widely accepted theories of what lies behind inequalities in health: behavioural, psychosocial, material, and life-course approaches.

Davey Smith, G. (2003). *Health inequalities: Life-course approaches*. Bristol: Policy Press.

The life-course perspective on adult health and health inequalities is an important development in epidemiology and public health. This volume presents innovative, empirical research that shows how social disadvantage throughout the life course leads to inequalities in life expectancy, death rates, and health status in adulthood.

Graham, H. (2004). "Social determinants of health and their unequal distribution: Clarifying policy understandings." *Milbank Quarterly*, 82, 101–124.

This article outlines some of the emerging issues in the social determinants of health field and details how their consideration influences the framing of problems and their potential solutions.

Hofrichter, R. (Ed.). (2003). *Health and social justice: Politics, ideology, and inequity in the distribution of disease*. San Francisco: Jossey-Bass.

This volume offers a comprehensive collection of articles written by expert contributors representing the fields of sociology, epidemiology, public health, ecology, politics, organizing, and advocacy. Each article explores a particular aspect of health inequalities and demonstrates how these are rooted in injustices associated with racism, sex discrimination, and social class.

Raphael, D. (2007). *Poverty and policy in Canada: Implications for health and quality of life*. Toronto: Canadian Scholars' Press Inc.

This book focuses on how the social determinants of health cluster to create the most disadvantageous life circumstance: Poverty. It includes information on the lived experience of poverty, how public policy shapes its incidence, and how poverty shapes health and the quality of life.

Raphael, D., Bryant, M., & Rioux, M. (2006). *Staying alive: Critical perspectives on health, illness, and health care*. Toronto: Canadian Scholars' Press Inc.

This book provides a range of approaches for understanding health issues. In addition to traditional health sciences and sociological approaches, this new book also provides the human rights and political economy perspectives on health. It focuses on these issues in Canada and the United States, but provides an international context for these analyses.

Related Web Sites

Canadian Centre for Policy Alternatives (CCPA)—www.policyalternatives.ca

The centre monitors developments and promotes research on economic and social issues facing Canada. It provides alternatives to the views of business research institutes and many government agencies by publishing research reports, sponsoring conferences, organizing briefings, and providing informed comment on the issues of the day from a non-partisan perspective.

Canadian Senate Sub-Committee on Population Health—tinyurl.com/ypwhhq

This Senate committee has undertaken to examine and report on the impact of the multiple factors and conditions that contribute to the health of Canada's population, known collectively as the social determinants of health. The Web site contains transcripts of witnesses' presentations and will eventually produce a report on the issue.

Centre for Social Justice (CSJ)—www.socialjustice.org

The CSJ's work is focused on narrowing the gap between rich and poor, challenging corporate domination of Canadian politics, and pressing for policy changes that promote economic and social justice. It provides information, statistics, and reports on the gap between the rich and the poor, housing, and other issues related to social determinants of health.

National Council of Welfare (NCW)—www.ncwcnbes.net

The NCW advises the Canadian government on matters related to social welfare and the needs of low-income Canadians. NCW publishes several reports each year on poverty and social policy issues, presents submissions to parliamentary committees and Royal Commissions, and provides information on poverty and social policy.

World Health Organization Commission on the Social Determinants of Health (CSDH)—www.who.int/social_determinants/en/

The CSDH supports countries and global health partners to address the social factors leading to ill health and inequities. It draws the attention of society to the social determinants of health that are known to be among the most important causes of poor health and inequalities among and within countries.